State of Maryland / Department of Health and Mental Hygiene Q Q

27501.

Physician	- 1	. Decedent's Name	(First Middle Lee	e)	-	Certific			2. Date of De	Reg. No.		3. Time of Death
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State Registrar 31. Dete filed (Month, Dey, Year)

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64 FRANKLIN ST AAm C

Amended 4 per F.D. Carroll Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. County 11/12/99 - jab State of Maryland / Department of Health and Mental Hygiene Q Q 37502 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year Physician Melva B. Radcliffe 10th 1aga NOV 3100pm /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Courcell Luthern Village Debry Ho 5 Sociel Segurity Mumper 6. Sex 7. Age (In yrs. last biodiay) Course M. Home westminuter If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 X F Months Deys Hours Min. **Director** 9 MD Usual Residence of Deceden the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1. Yes 2 □ No MD Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 200 St. Luke Circle 21158 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. 11. Meritel Stetus Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home other 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be facilities of Health and Mentel Int: If Item 27 is marked of Charles Bollinger Margaret Jordan 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 701 W. Joppa Road Allison Long/Granddaughter 21204_{Dete} other 20b. Plece of Disposition (Name of cometery, cremetory or other plece) Baltimore, 20e. Method of Disposition 20c. Location - City or Town, State 1 □ Buriai 2 □ Cremetion 3 □ Removel from State 9 permit. Page Department of Important: If any injury or 4 ☐ Donetion _5 ☐ Other (Specify) John's Cemetery 11/13/99 Ellicott City, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 Part Enter the Composition that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, book or the inflation. List only one cause on sections. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine) Sepsis

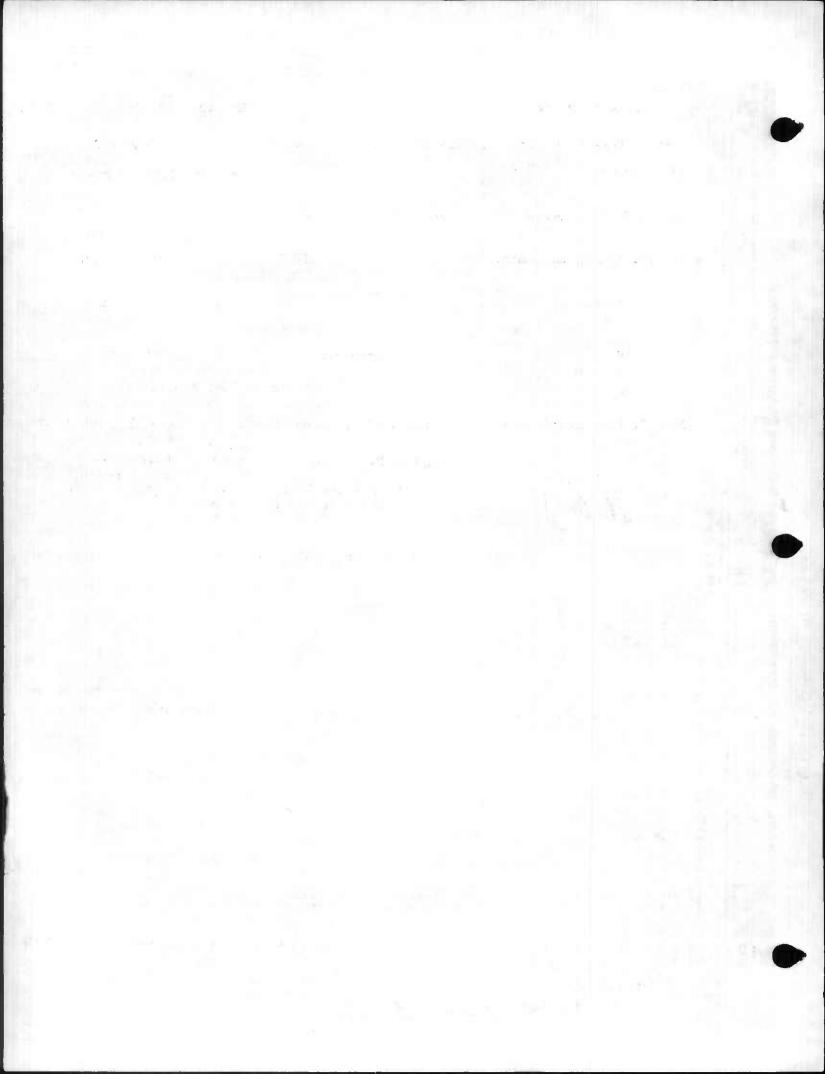
Due to (or es e consequence of): 4 chuys disease or condition resulting in deeth) Examiner Examiner physicien and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760. certificate be Physician/Medical that initiated events resulting in deeth) Lest Due to (or es e consequence of) 80 USB ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed b End Steve e Dementra 2 24b. Were eutopsy findings aveilebie prior to Completed 24e. Wes en autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: funeral director, Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 25 No this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Neturel 5 Pending or Attendin efter death. Director: Aft investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours Contifying Physician: To be best of my showedge) death occurred at the time, date and place, and due to the cause(s) and menner as stated.

If Medical Extrainer: On the basis of training in the stated of the time, date and place, and due to the cause of the time, date and place, and due to the cause of the time, date and place, and due to the cause of the time, date and place of the time, date and place of the time. 29a. Certifier Medical (Check only one) ion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) To the To the To the I 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier Nov. 11th 1999 1237949 30. Neme end eddress of person who comple e, Print) 21157 Ateroacher Bugelascheush 205 St. Mente Way, Westminister, MN. 31 Dete filed (Month, Dey, Year) 2 1999 Registrar

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	John G.	Reising	er/Hu	sband		199 R	ollins A	venue.	Apt. 612	Rocky	ille.	MD 20852
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REISINGER, ANNE



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death NOV. JAMES 0. RIDGLEY 11, 1999 11:30 PM 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Daath Washington Adeventist Hospital MONTGOMERY Birthplace (Stata or Foraign Country) 1**X**M 2□ F 578-22-1185 Wash. Usuai Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1M Yas 2 No Pr. Geo. Adelphi 10f. Zip Coda 10g. Citizan of What Country? 9319 Riggs Road 20783 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas?

①② Yas 2 □ No if Yes, Giva Yaar or Datas: 44-46 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, White, atc. 1 □ Navar Marriad 21X Marriad 1 ☐ Yas 2 ☐ No Specify: Specify: Black 3 ☐ Widowad 4 ☐ Divorced 15. Dacedant's Education 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Postman U.S. Postal Serv. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) Arville Ridglev Annie Diggs 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Alice E. Ridgley (Wife) 9319 Riggs Rd., Adelphi, MD 20783 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Ramoval from State Mt. Olivet Cem. 4 ☐ Donation 5 ☐ Other (Spacify) 11/18/99 Wash. DC 21. Signature of Funeral Sarvice Licentic 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. BOCKVILLE, MD 20850 and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, hock, or hear failure. List only one cause on each line. Approximata Interval Bar Intarval Batween Onset and Death EUKEMIA MONOCYTIE

Dua to (or as a consaguance of): Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? CLINICALLY(2) SYSTEMIC MASTOCYTOSIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of ceuse of daath? RENAL INSUFFICIECY (DJE HYDRRATION 24a. Was an autopsy performed? CORONARY ARTERY DISTASE @ PIA BETES
AS CESA referred to medical 25. Was cesa rafarred to medicel axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Dinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding 1 Tyes 2 No invastigation 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated.

29d. Data signed (Month, Day, Yaar)

Division of Vital Records, P.O. Box 68760.

/Medical Examiner The law requires that the death certificate be executed this certificate hes Attending Physician: To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 16

Physician

/Medical

Examiner

Funeral

Director

must be notified at

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Certification:

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death with the Maryland

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Baltimore, Maryland 21215-0020

5. Social Sacurity Number

10e. Street and Number

12th

20a. Mathod of Disposition

Immediata Causa (Final disaasa or condition rasulting in death)

Sequantially list conditions, if any, laading to immadiata causa. Enter Undarfying Causa (Disaasa or injury that initiated avants rasulting in daath) Last

10a State

State Registrar

27. Manner of Death

1 Natural

2 Accident

3 Suicida

29a, Cartifiar

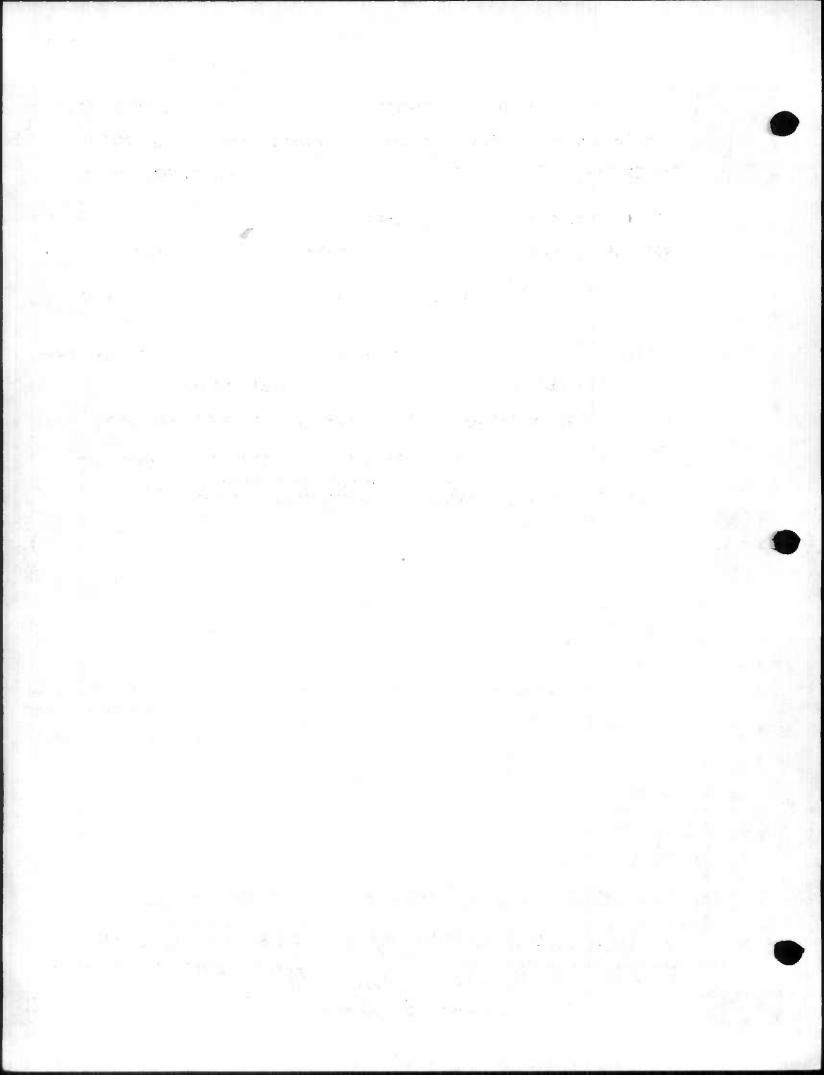
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29b. Signature and title of certifian

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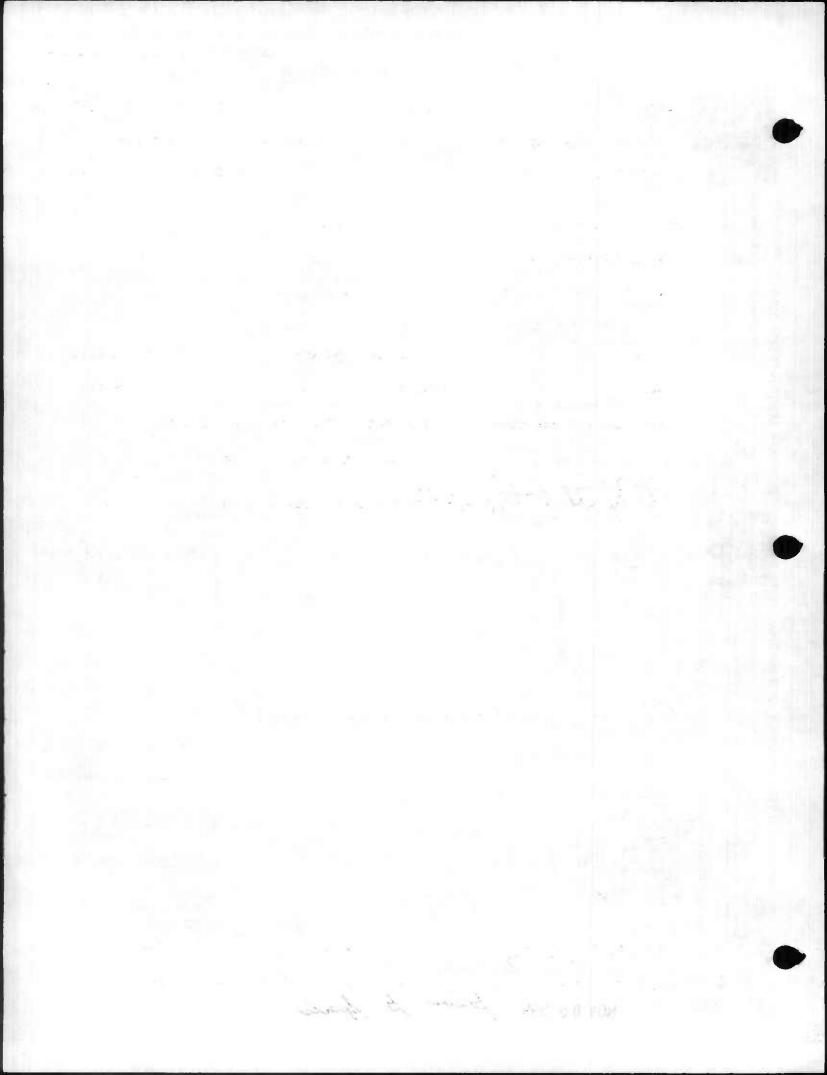
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TOLEDO TERRACE, HYATTSVILLE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 37505

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State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day 1999 **Physician** NOVEMBER LORNA ELIZABETH STEELE 02:55 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner National Institutes of Health Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Jan. 22, 1 Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 2Ā F Yrs. **Director** unknown 46 1953 Jamaica Usuei Residenca of Decadent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No West Indies St. Catherines Direct 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours efter death v. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a and injury or other traumatic evant, the Medical Examiner musts once. Jamaica Funeral P.O. Box 186 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 11. Meritel Status 1 ☐ Yes 2X No If Yes, Give Year or Detes: 1 Never Married 2 X Married 1 ☐ Yes 2 No à Specify: 3 ☐ Widowed 4 ☐ Divorced Black. 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 2yrs. Secretary Harco Trading Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Frederick Hart Patricia Murdock 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bannister P. O. Box 186 Old Harbour, P. O. St. Catherines, Jamaica, West In. Ronald Steele/Husband 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 11-20-99 St. Catherines, Jamaica Dovecot Cemetery 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011 23e. Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in deeth) · MULTISYSTEM ORGAN FAILURE DAYS Examiner Due to (or es a consequence of): Examiner ALLOGENMC WKS BONE MARROW TRANSPLANT physician and s the buriel-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): 3 yrs MULTIPLE MYELOMA Physician/Medical Due to (or es e consequence of) for use as I signed by the a Pert Ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Graft VS HU ST DISEASE à 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Completed with s certificate has b director, page 2 s 2 No 1 ☐ Yes 2 No funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitei: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Menner of Death 26a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending Investigation 1 Neturei 2 Accident or Attending after death. Director: Aft 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 5 4 Homicide building, etc. e Hospital n 24 hours a To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) and manner as steted. Medical 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. 29b. Signature and title of certifier 29c. License number (MD) 29d. Date signed (Month, Day, Year) NOV D0052707 30. Name and address of person with impleted cause of deeth (item 23a) (Type, Print) NIH - CCMD regor 1. MD MALCHIO (onth, Day, Year) 31. Date filed Registrer's Signature 0 4 1999

State Registrar

Division of Vital

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with

Baltimore, Maryland 21215-0020

Similar & mand 8681:01

State of Maryland / Department of Health and Mental Hygien Q 37507 Certificate of Death 2. Dete of Deeth

<i>,</i>	Physician /Medica Examine
H	Funeral Director

with the Maryland

d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at filed within 72 hours after Hygiene. permit. Pages 1 and 2 should be file.
Department of Health and Mental Hys.
Important: If Nem 27 is marked othe
any injury or other traumatic event,
and.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and s the burial-transit law requires that the death certificata be executed Box 68760, attanding p signed by the a Division of Vital Records, P.O. been s paga 2 s The certificate or Attending Physician: director. this After this funeral d death. Director: A in by To the Hospital or within 24 hours aft To the Funeral Di

1. Decedent's Name (First, Middle, Lest) 3. Time of Deeth Month Dev EDWARD T. SPINNER NOVEMBER 1, 1999 21:04 PM 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Undar 1 Year 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign
Country) Deys Months Yrs. MAY 22, 1947 WASHINGTON, DC 577-60-8949 Usual Residence of Daceden 10d. Inside City Limits 10a Stete 10h Counts 10c. City. Town or Location X Yes 2 No Directo WASHINGTON, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 2216 DOUGLAS STREET, N.E. 20018 UNITED STATES Funeral 14. Race - Amarican Indian, Bleck, White, etc. 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 No It Yas, Give Wes Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Never Merried 2 N Married 1 Yes 2 No Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detas Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 TRUCK DRIVER SELF-EMPLOYED 18. Mother's Nema /First, Middla, Maiden Sumeme. 17. Fether's Name (First, Middle, Last) JOHN EDWARD SPINNER JOHNNIE MAE DRAYTON 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) NANCY L. SPINNER, WIFE 2216 DOUGLAS STREET, N.E., WASHINGTON, D.C. 20e. Method of Disposition 20b. Plece of Disposition (Nama of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stata 1 Burial 2 ACremetion 3 Ramoval from Stete 11/5/99 BRENTWOOD, MARYLAND 4 Donetion 5 Other (Spec LINCOLN CREMATORY 21. Signetyte of Funeral Service Lize 22. Nema and Address of Facility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Death Immadiata Causa (Final SEPSIS disaasa or condition resulting in death) Examiner MMUND Defreiency (AIDS) Sequentielly list conditions, if eny, laading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated avants resulting in deeth) Lest Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Failure Renal à 24b. Were eutopsy findings available prior to Completed malnutrition 24a. Wes en eutopsy completion of ceuse of death? 1□ Yes 2 No 1 TYes 2 No Be 25. Wes cese refarred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) al No Certification: To 1 Yes 27. Menner of Deeth Neturel 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding investigation 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end menner stated. edicai 29a. Certifier (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number wo D43662 30. Name end addrass of person who completed cause of daath (Item 23e) (Type, Print) 300/ Hosp Cheverh

Horp

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32. Registrar's Signeture

DHMH 16 Rav 6/95

State

Registrar

Nilli Am

31. Dete filed (Month, Day, Year)

0 4 1999

10 1 1 1999 James D. Moreta

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death OCTOBER 0730 1999 Archie Calvin Smith, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) PRINCE GEORGES CHEVERLY PRINCE GEORGES HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 24, 1937 North Carolina 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Hours Days 1₩ 2□ F 62 Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No District of Columbia Washington 10f. Zip Code 10g, Citizen of Whet Country? 3324 Carpenter St., S.E. 20020-2306 United States Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amaricen Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, Whita, atc. 1 Navar Marriad 2 Married Black 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Yaar or Detes 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Accountant Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Archie C. Smith, Sr. Bertha Watson 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rose L. Smith - Spouse 3324 Carpenter St., S.E. Wash., D.C. 20020-2306 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Deta 20c. Location - City or Town, Stete 1X Burial 2 Cremetion 3 Removel from Stete Cedar Hill Cemetery 11/6/99 Clinton, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensea 22. Name and Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, in heart feilure. List only one cause on each line. vous) Approximete Intervel Between Onset and Daath · ARTERIOSCIEROTIC CARDIOVASCULAR PREASE Due to (or es e consequence of) Due to (or es a consequence of): Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably Munknown 24b. Were autopsy findings eveileble prior to 24e. Wes en autopsy performed? completion of ceuse of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Invastigation

/Medical The law requires that the death certificeta be executed Records, P.O. Box 68760. Division of Vital Attending Physician:

Examiner ettending physician and for use es the bunal-tran signed by the ed been si is certificate has I this funeral After death. ofter death Director: A d in by the f in 24 hour. Hospital or

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at

Director

Funeral

by

Completed

Be

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Physician/Medical

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Certification:

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filed within 72 hours after

Hygiene.

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permit. Peges 1
Department of H
Important: If itel
any injury or ott

Physician

other

altimore, Maryland 21215-0020

5. Social Security Number

10e. Street and Number

20a. Method of Disposition

Immediate Cause (Finel

Sequentielly list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in daath) Last

exeminer?

6 Could not be determined

27. Menner of Deeth

1 Naturel

2 Accident 3 Suicide

4 Homicide

31. Dete filed (M

disease or condition resulting in deeth)

238-46-0229

Usual Residance of Decedant

To the h within 24 To the F complete

State Registrar

29e. Certifier 1 Certifying Physician: To the best of my kingwiedge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. (Check only one) Medical Examiner: On the besis of examiner and menner stated minature end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) 29b. Signatury 29d. Dete signad (Month, Day, Year)

1 ☐ Yes 2 ☐ No

death (Item 23a) (Type, Print)

DRIVE

Location (Street and Number or Rural Route Number, City or Town, State)

32. Registrar's Signature

28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

pow p. deal.

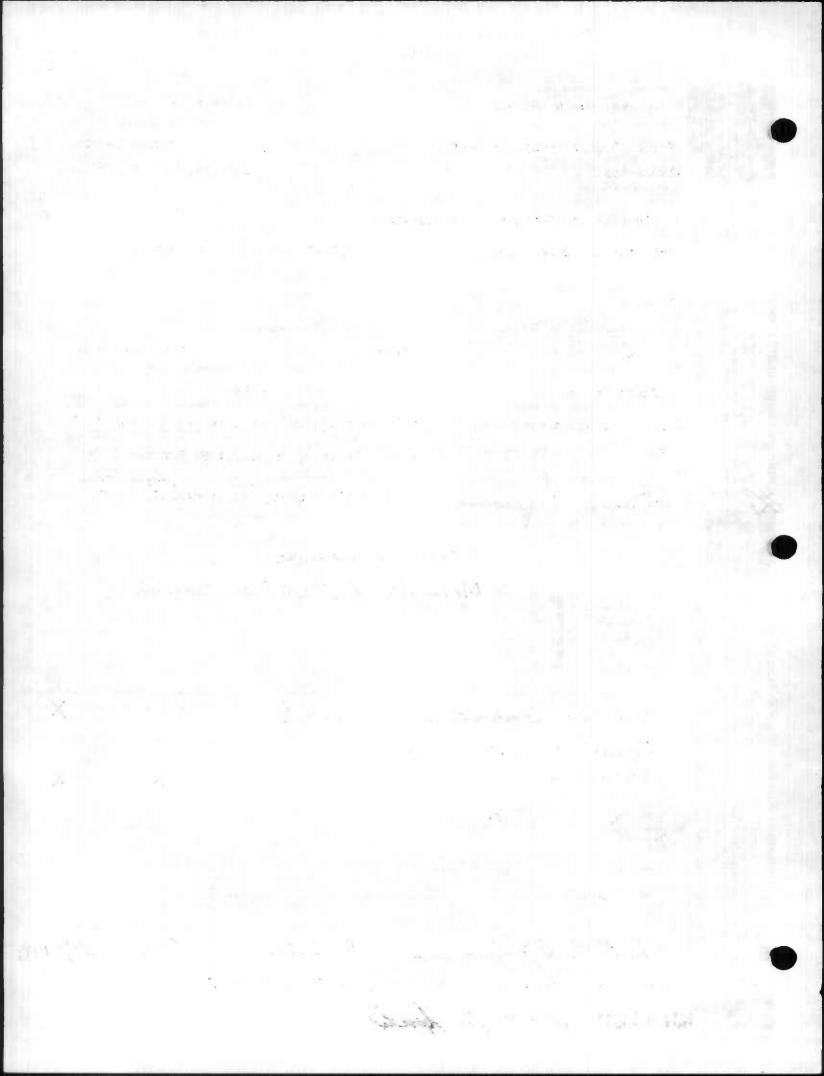
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State of Maryland / Department of Health and Mental Hygiene 99 3750

				Certificate	of Death	F	leg. No.	3/509
	Dharistan	1. Decedant's Name (First, Middla, Last)	. 3 . 34			2. Data of Dea Month		3. Time of Death
	Physician /Medical	Frances Ceola St	rong			October	28°, 199	8:50 P.M.
	Examiner	4a Facility Neme (If not institution, give stre	et and number)		4b. City, Town, or I	ocation of Death	4c. County of	Death
		Prince Georges Hosp		st hirthday) If Undar	Cheverly	10 Day 40'4	Prince	Georges
ı	Funeral Director	373-20-4032	7. Aga (In yrs. la	Yrs. Months	Days Hours Min.	8. Data of Birth Month, Day July 24	1922 N	9. Birthplace (State or Foreign Country Orth Carolina
	pue &	Usual Residence of Dacedant 10a. State 10b. County	10c. City,	Town or Location				10d. Insida City Limits
	4 sho	Maryland Prince Geor	rges Fore	stville				1 ☐ Yas 200 No
	or 28a-f s	10e. Street and Number	8-0	10f. Zip	Coda	1	0g. Citizan of Wh	nat Country?
	3a o	1847 Addison Road S	South		20747		U.S.A.	
21215-0020	72 hours efter deeth with the Manyland naturel; or items 23a or 28=4 show doel Examiner must be notified at each by Funerst Director	1 Navar Marriad 2 Married XXX Widowad 4 Divorced	Wes Decedant Ever in U,S Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva A Yaar or Datas:	. 13. Was Dacedo	ant of Hispanic Origin? (Sify Cuban, Maxican, Puart	pecify Yas or No- pecify Yas or No- pecify Yas or No-	Black,	Americen Indian, Whita, atc. Black
2-0	"naturel",	15. Decedant's Educeti (Specify only highast grada co		16e. Decedant's Usual	Occupation k done during most of wor	kina	16b. Kind of Bus	inass/industry
21	ed within 72 ho ygiene. Ar than "natural, the Mod call Completed	Elamantary/Secondary (0-12)	Collage (1-4or 5+)	lifa. DO NOT use	e retired)	ang.	II C - C	
2	other th			Custodian	40 Mathada Nas	o (Final Adiololia		vernment
anc	8 5 F 6						<i>Maldan Sum</i> ama,	
Maryland	should nd Men arke umatic	James Strong 19e. Informant's Neme/Relationship (Type,	Print)	10h Mailing Addrage	Effie G: (Streat and Number or Ru		City of Town S	tete Zin Code
Ma	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2	Shirley A. Reese/Day			on Rd. South			
re,	s 1 end f Health item 27 other tr	20a. Mathod of Disposition	20b. Pla	ce of Disposition (Nam	a of	Data		ity or Town, Stata
Saltimore,	90-	1 Donation 5 ☐ Other (Specify)		matary, crematory or of Lincoln Ce	metery Nov	3,1999	Brentwo	od, MD
H	Department Department Important: 9 ony Injury o	21. Signature of Funeral Service Licensee		22. Nama and	Addrass of Fecility Ft	I incol.	Funomo	1 Uomo
m	E E E	18 16		3401 B	ladensburg l	Rd. Bren	twood. M	D 20722
2	1	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ions that ceused the death.					Approximeta Intervel Between
68760,	the death certificate be assected The strength of the strengt	Immediate Ceuse (Final diseasa or condition resulting in deeth) Sequentially list conditions, if any, laading to immadiate ceuse. Enter Underlying Causa (Disaase or Injury that initiated events			DROME cidosis/A	Bacter	kemià.	
	E 0 8 5	rasulting in death) Last	Dua to (or a	as a consaquance of):]]]
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of Vital Records,	been shou	SACRAL Dec	who vosc	erl		24a. Was a perfor	an autopsy mad?	24b. Wara autopsy findings eveileble prior to complation of cause of daath?
Ä	0 - 0 -	Volvolon				1 🗆 Y	as 200No	1 Yas 2 No
ita	ysicien: The sector, per director, per Co Be Co	25. Was cese referred to medical axaminar?			26. Piece of Dea	th (Check only o	na)	
>	2 00 5	1 Yas 2 No	pital: 1 Mnpatiant 2□ E	R/Outpatient 3□ DO	A Othar: 4 Nursing H	oma 5 Rasid	ance 6 Other	(Specify)
ion o	After fune	27. Menner of Death 1 Naturel 5 Panding 2 Accidant investigation	28a. Data of Injury (Month, Day Year)	28b. Tima of tnjury M	3c. Injury at Work? 1 ☐ Yas 2 ☐ No	28d. Describe h	ow injury occurre	d
Division	To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be dataminad	28a. Place of Injury - At hon building, atc. (Spacify)	na, farm, straat, factory	office	28f. Location (S City or Tow	treet and Number n, Stata)	r or Rurat Routa Numbar,
	To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by Medical Certifi		an: To the best of my know On the bests of exeminetic and mannar statad.					
	withir Comp	29b. Signeture and titla of certifier	1	29c.	License number			(Month, Day, Year)
	1	1. Kulmet	Xua	_ 0	0052865		Octobe	v 28, 1999
	(3)	30. Nama and addrass of person who some						
	9	K. Michael Figure M	I.D. 7202 Qui	sinberry Wa	ay Bowie, MD	20715		
	01-1-	31. Data filad (Month, Day, Year)	32. Ragistrar's Signatu	Ira .				

DHMH 16 Rev 6/95

Registrar



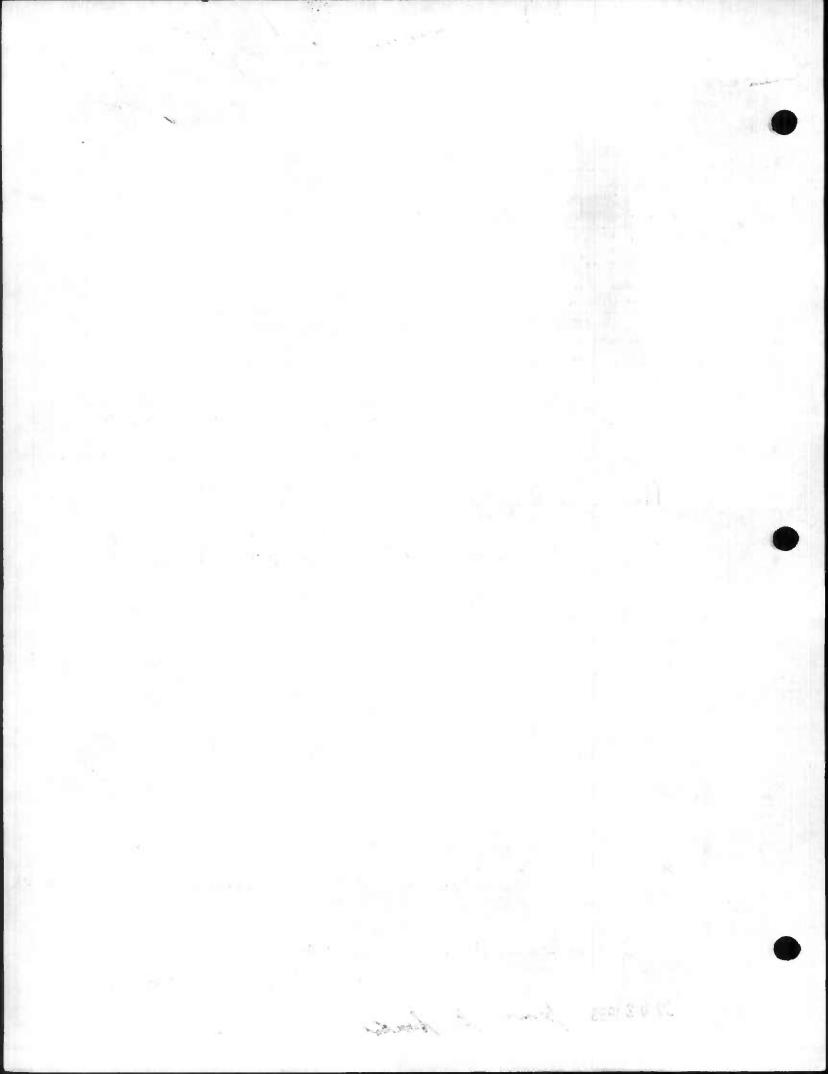
Earnest Colden Smith

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 7 5 1 0

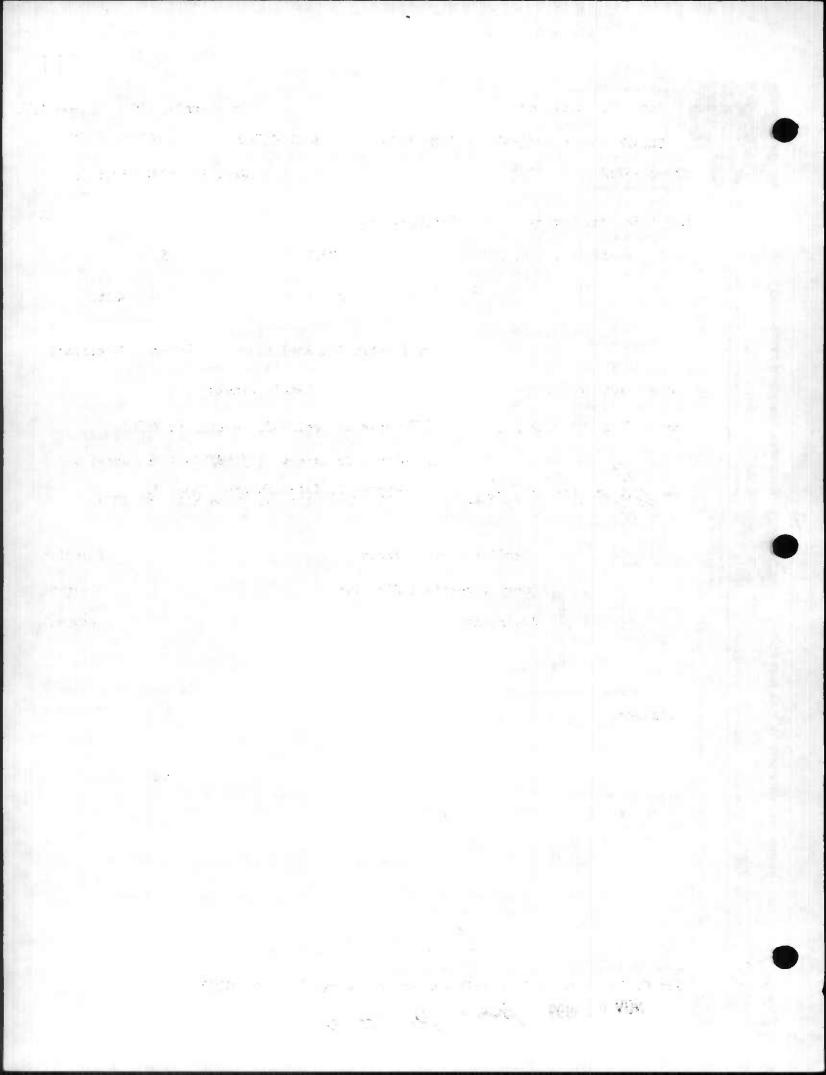
				Certificate of	Death	R	eg. No.	9 3	1010	
→ Physician	1. Decedent's Neme (First, Middle, La					2. Data of Dea Month	th Dey	Year	3. Tima of Death	
/Medical	EARNEST COLDEN	SMITH				Octobe			09:20 PM.	
kaminer	4s Facility Neme (II not Institution, given		2 46		4b. City, Town, or Lo		4c. County	of Deeth		
		6609 Wood.			Clinto		_	ce Geo	rge's	
eral ctor	247-54-9073	Sex 7. Age	(In yrs. last birth	day) If Under 1 Yea Months Day		8. Dete of Birth (Month, Dey June 1,	Year) 1937	9. Birthpled Country South	Carolina	
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d	. Inside City Limits	
Irector	Maryland Prince	George's	Clinto						1⊠Yas 2□No	
ral Dire	10e. Street and Number 6609 Woodley Ro	ad		10f. Zip Code 207	735	1	10g. Citizen of What Country?		7	
by Funeral Director	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detes:		13. Was Decedent of If Yes, specify Cu 1 Yes 2 No.	Hispanic Origin? (Speban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ee - American ck, White, etc v: Blac		
e de	15. Decedent's E (Specify only highast gre	ducation ade completed)	16a. C	Decedent's Usual Occi	upation e during most of worki ed)	na	16b. Kind of Bu	usiness/Indus	stry	
Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Realtor	ed)		Priva	te		
To Be C	17. Fether's Neme (First, Middle, Last Chatman T. Sr	nith			18. Mother's Neme			na)		
	19e. Informent's Neme/Relationship (et end Number or Rurs					
To Be Comp	Rosa L. Smith/W	ire			y Road, Cl					
any injury or other tr phos.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☑	Removel from State		Disposition (Name of cremetory or other p	-	1/05	20c. Location -			
	4 □ Donetion 5 □ Other (Specif		westey	Cemetery		999	Bennett	SVIIIE	2, 3.6.	
Suce.	21. Signeture of Funeral Service Lice	nsee		22. Nama end Add	rass of Facility KINS FUNER	AL HOME				
	Nancus A.	lercen he			over Road,		er, Mar	yland	20785	
	23a. Pert1. Enter the disease, or com shock, or heert failure. List only	plications that caused t	he death. Do no	t enter tha mode of d	ying, such as cardiac o	or respiratory arr	est,	A	pproximete itervel Between	
cian	SHOOK, OF HEER FAILURE. LIST OFFIN	One cause on each line		1 1	1 /			10	nset and Death	
lical	Immediate Cause (Final	C	in sla	-+ /	Louised	2.	140	ad		
ner	diseasa or condition resulting in death)	a. 0 00	VI DVC	o l	MUNICA	TO .	110	na		
ě			due to (or as a co	insequence or):						
Medical Examiner	Sequentially list conditions	b	ue to (or as a co	usednesce off.						
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury		10 (01 00 0 00							
Cal	that miliated events	c	ue to (or es a co	nsequence of:						
Pel	resulting in death) Last	b	-3 10 10 00 00							
2		d								
Physician/	Pert It. Other significant conditions of	contributing to death but	not resulting in t	he underhing course	niven in Part I	23h Did to	hacco use of	ntribute to 4	he causs of death?	
hys	. O. C. Other argininount continuous c	withouring to death but	not resulting in t	THE UNITED IN THE CAUSE (prominicult.	1 🗆 Y	./		biy 4 Unknown	
				3-21		101	2 HO	O From	, Unknown	
should be beteched leted by Physic						24a. Wes e	n eutopsy	24b. Were	eutopsy findings	
Completed by						perform	med?	comp	able prior to eletion of cause	
E						_/		of de		
						1 0 Y	s 2 No	1021	res 2 No	
Be	25. Wes case referred to medical examiner?	Hospital:		1_	26. Placa of Deeth	(Check only on	(e)			
To Be	12 Yes 2 No	Hospitel: 1 Inpatien		atient 3LI DOA		me 5 🛚 Reside				
	on 14	ury et ork?	28d Describe ho	w injury occur	red 1	1				
	27. Manner of Death 1 Neturel 5 Pending	28a. Dete of Injury (Month, Day	27. Manner of Death 1 Neturel 1 Neturel 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et linjury Work?							
	1 Neturel 5 Pending Investigation	n 10/27/99/E	and 9:1			Jub	ilel	28f. Location (Street and Number or Rural Route Number, City or Tokes, Stete)		
	1 Neturel 5 Pending Investigation Suicide 8 Could not be	Month, Day	v - Al home, fem			28f. Location (Si	reet and Numb	per or Rural F	Route Number,	
	1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 8 Could not b	Month, Day	y - At home, fem (Specify)	0 FM 11		281. Location (Si City or Toke	met and Numb Stete)	per or Rural F	Oto Number, Clinten, Ma	
	1 Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not b determined	Month, Day	y - At home, fem (Sperify) my knowledge, examination and/	n, street, fectory, office	e (time, date and place,	elo OM	weedle	y Rd;	Clinton, Ma	
ffication:	1 Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not b determined 29a. Certifier (Check only Check only 2 S Medical Exam	(Month, Day 2 In. Plete of Injurbuilding, etc. Systician: To the best of Injurer: On the basis of e	y - At home, fem (Sperify) my knowledge, examination and/	n, street, fectory, office death occurred et the or investigation, in my	e (time, date and place,	end due to the co	weedle	Phoer as state and due to the	Clinten, Ma	
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Registrar



State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle	e, Last)						2. Date of D	eath Day	Year 3	. Time of Death
nysician Medical	Mary G. Ste	einberg						Octobe			1:08 A.M
xaminer	4a Facility Name (If not institution	, give street and numb	er)				4b. City, Town, or	Location of Dea	th 4c. County	of Death	
	SHADY GROVE	E ADVENTI	ST HO	OSPITA			ROCKVII			ITGOME	RY
neral ector	5. Social Sacurity Number 577–24–5762	6. Sex 1 M 2 F 7.	Aga (In yrs.	last birthday) 7 Yrs.	If Under Months	1 Year Days	If Undar 24 Hrs. Hours Min.	(Month, D	th ay, Year) 5, 1921	9. Birthplace Country) Virgin	e (Stete or Foreign ia
-	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d.	Inaide City Limits
ust be notified at ral Director	Maryland Montgo	omerv	Ga	ithers	niro						1 ☐ Yas 2 X No
irec	10e. Street and Number	J.mer y		z cher or	10f. Zip	Code			10g. Citizen of	What Country?	>
a O Is	401 Russell Ave	e. Apt. #61	6			208	377		U.S.A.		
Fune	11. Marital Status 1 Never Married 2 Marr 3 X Widowed 4 Divorcad	If Yes, Give	s? XNo				dispanic Orlgin? (S an, Mexican, Puerl Spectfy:	pecify Yes or N o Rican, etc.)		ce-American i ck, White, etc. y: White	
once. To Be Completed by	15. Decedent	t's Education		16a. Deced	lent's Usua	al Occup	eation during most of word d)	rkina	16b. Kind of B	usiness/Indust	try
mpidu	Elementary/Secondary (0-12)	College (1-4	or 5+)				a Assista		Federal	Couran	nmant
S	17. Father's Name (First, Middle,	(ast)		11(1)1111	Locia	CIVE			e, Maiden Sumar		IIIIeII E
Be	James Luther (s, maiosii oamai		
5	19a. Informant's Neme/Relations			19b. Mallin	ng Addrass	(Street	Glennie and Number or Ri		ber, City or Town	State, Zip Co	de)
Í	Scott H. Jenkir									7O1	
,	20e. Method of Disposition	•		Place of Dispos cemetery, crem	sition (Nar	me of	ve.#300,	Date	20c. Location	- City or Town,	State
	1 ☐ Burial 2 ☑ Cramation 4 ☐ Donation 5 ☐ Other (Si		118	tropoli				0/30/19	99 Alexa	ndria.	VA
once	21. Signature Juneral Service	Corpson /)		22	. Name an	nd Addre	ss of Facility				
8	+ spage V	. Tala	1	61	eorge 60 0	Yon	Kalas Fu Hill Rd.	neral H	ome, P.A Hill MI	20745	
	23e. P. Emy the disease, or shock, or part failure. List	complications that cau	sed the dea	th. Do not ente	er the mod	de of dyin	ng, such as cardia	c or respiratory	arrest,	Ap	proximate erval Between
an										Or	nset and Death
icai ner	Immediate Cause (Final disease or condition resulting in deeth)	a. Cardio	pulmo	nary Ar	rest					Im	mediate
- E			,	or as a conseq		,					
edicai Examiner		- Gastroi								Mi	nutes
edicai Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	Aspirat		or as a consaq	uenca ot):					M.	nutes
Ca	Cause (Disease or Injury that Initiated events	c.		or as a consequ	neuce of).					I'IL.	nuces
	resulting in death) Last		200 10 (0	51 45 4 001130q1	001100 017.						
/ Physician/Me		d									
SICI	Part II. Other significant condition	ns contributing to deat	h but not res	sulting In tha ur	nderlying o	ause giv	ven in Part I.	23b. Die	tobacco use co	ontribute to the	e cause of death?
Phy	Diabetes							10	Yes 2□ No	3 Probab	ly 4 🔀 Unknow
d by P										045 141	outono- findi
Completed by Physician/M								24a. Wa	s an autopsy formed?	evallal	eutopsy findings ble prior to letion of cause
mpieted										of dea	ith?
S	05 W								Yes 2XXNo	1 🗆 Ye	es 2 No
orrector, page To Be Com	25. Was case referred to medical examiner?	Hospital:	-41	3.EDIC · ·		Oth	26. Place of De			(6	
	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of I	njury	ER/Outpatien 28b. Tima of		28c. inju	4 LI Nursing r		how Injury occu		
itior	1 ☑ Naturel 5 ☐ Pendin 2 ☐ Accident investig	g (Month,	Day Year)	Injury	M		rk? Yes 2□No				
Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 286, Placa of	Injury - At h etc. (Speci	nome, farm, stre fy)	eat, factory	y, offica		28f. Location City or To	(Street and Num. own, State)	ber or Rural Re	outa Number,
Medical Cert		g Physician: To the be Examiner: On the basi and manner	s of examina								
completely filled in b	29b. Signature and title of cartified	/	1/			c. Licens	se number		29d. Date signe	ed (Month, De)	v, Year)
¥ South			1	11 0							
W	•	20		M. D.	1.	000	54139		October	128, 190	79



State of Maryland / Department of Health and Mental Hygiene O O

				Otato of	ivial y lair	Cer	tificate o	f Death	G Montan	Reg. N	-	3	1512
	Physician (Medical	1. Decedent's Name Ne1) Viola	Sch	eidegg	er		2. Date of Month NOV 1	D	ey 9	Year	3. Time of Death 1:00 A.M
)	· /Medical Examiner	4a Fecility Neme (# Washing	not institution, give ton Adver					4b. City, Town, Tokoma	or Location of De		c. County	of Death	
	Funeral Director	5. Social Security No. 578 30-7	968	9x □ M 2 X F	Age (In yrs. 99	last birthday) Yrs.	If Under 1 Ye Months Day		din. (Month,	Birth Dey, Year		9. Birthpl Count SW1t	lece (Stete or Foreign try) zerland
	nend wo	Usuel Residenca of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10	Od. Inside City Limits
	a-f sh	MD	Montgome	ery	T	'akoma	Park						1 ☐ Yes 2 ☐ No
	or 28	10e. Street end Nun	ber				10f. Zip Code				itizen of W		•
	a 23a		roll Ave	40 111 - 5 1	E 1- 14	0 1401	125		0.40		ted S		
21215-0020	filed within 72 hours after death with the Marylend thygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at ent. The Medical Examiner must be notified at each of the Medical Examiner must be notified at each of the Medical Examiner must be notified at each of the Medical Examiner must be notified at each of the Medical Examiner at the Medi	11. Marital Status 1 Never Marrie 3 Widowed		12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	es? □₩lo		Yes, specify C	of Hispanic Origin' uban, Mexican, P lo Specify:	7 (Specify Yes or uerto Rican, etc.)	No-		- America k, White, e	
2-0	ygiene. ygiene. rt, I'm Medical rt, I'm Medical	(Space	15. Decedent's Edition only highest grad	ucation		16a. Deced	lent's Usual Occ	cupation ne during most of ired)	warking	16b.	Kind of Bu	siness/Ind	lustry
121	be filed within 72 ho titel Hygiene. d other than "natur event, the Medical Be Completed	Elementary/Secon		College (1-4	or 5+)		SSionar		WOIKING	(II-)-	T)?-	an a
	Hygiene. Hygiene. Ather than	12 17. Father's Name (First Middle Lest)			IVIL	SSIONAL		Name (First, Mid				SDA Church
Maryland	Sec 9	Unknown									on Sumann	9)	
ary	s 1 end 2 should be f Health end Mentel item 27 is marked o other traumatic ev	19a. Informant's Na		ype, Print)		19b. Mailin	g Address (Stre	eet and Number o	lia Ette		or Town,	State, Zip	Code)
Σ		Walter	Scheidego	ger (SON))	P.O.	Box 12	66 Front	Royal,	Virg	inia	2263	0
ore	00-	20a. Method of Disp	osition ACremetion 3 🔲	Domewal from Ctr		laca of Dispo	sition (Name of natory or other p		Date		Location -		
Ē	Pag net: If int: If		5 Other (Specify			e Crem	atory N	ovember	11. 1999	CI	inton	.Mar	vland
Baltimore	pemit. Page Department of Important: If any injury or once.	21. Signature of Fur	ural Service vicers	#	1095	22 7.1	. Name and Ad	dress of Facility La Ferry	ee Funer	al H	ome, I	nc 6	633 Old
	Physician	23a. Part1. Enter th	e disease, of comp t failure. List only o					dying, such as car		y errest,			Approximete Interval Between Onset and Death
Å	/Medical Examiner	Immediate Cause (I disease or condition	Final	. C.	onges	tive	Heart	Facture					6 months
	SECTION AND ADDRESS.	resulting in death)			Due to (o	ras a conseq	uence of):						
	executed in end ial-transit Examiner		•	bC				iseoic					205eors
,	n end ial-tra	Sequentially list con If any, leading to im-	ditions, mediate		Due to (o	ras a conseq	uenca of):						
68760,		Sequentially list con If any, leading to im- cause. Enter Under Cause (Disease or I that initiated events	njury	C	Due to (o	r as a conseq	uence of):						
	1 00	resulting in death) L	ast	d	,								
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P.O.	res that the designed by the elibe deteched for by Physic	Part II. Other signifi		_		-				old tobacc	2 No	3 Prob	the cause of death?
	igned to be det	HEri	el Pib	rillozia	4					_ 100	2	0	abiy 4 dimini
Records,	The law requires that the deeth cersite has been signed by the ettending page 2 should be deteched for use Completed by Physician/N	Chro	al Fib	structi	eve	Pulmo	non	Disease	24a. V	as an autarformed?	topsy	COL	ere autopsy findings bileble prior to mpletion of cause death?
<u>a</u>	certificate harector, page								1	☐ Yes	2 XNo	1 🗆	Yes 2 No
of Vital	clan:	25. Was case referre		11 - 2 1					Death (Check or	ly one)			
of	hys his el di	1 □ Yes 2 🔀	NO	Hospital:		ER/Outpatien	1 3LI DOA		ng Home 5 R)
no	After funer funer	27. Manner of Death	5 Pending Investigation	28a. Date of I (Month,	Day Year)	28b. Time of Injury		njuryat Vork? □ Yes 2 □ No	28d. Descri	be how in	jury occurr	ed	
Division	tal or Attending P rs efter death. al Director: After t led in by the funer Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	289. Place of	Injury - At ho , etc. (Specif)	ome, farm, str	et, factory, offi		28f. Locatio City or	n (Street : Town, Sta	and Number ate)	er or Rura	I Route Number,
	To the Hospital or I within 24 hours efter To the Funeral Dire completely filled in E	29a. Certifier (Check only one)	1⊠ Certifying Phy 2□ Medical Exami	reician: To the be iner: On the basis and manner	s of examinal	wledge, death tion and/or inv	occurred at the restigation, in m	time, date and p y opinion, death o	lace, and due to occurred at the tir	he cause ne, date a	(s) and main nd place, a	nner as st and due to	ated. the cause(s)
	To the Comp	29b. Signature and		11			29c. Lice	ense number		29d. C	Date signed	(Month, I	Day, Year)
	7	1 0	hell lon	John	_		02	2309		Nov	ember	10	1958
	(5)	30. Name and addre		ompleted cause of	of death (Item	1 23a) (Type,	Print)						
	1		V. Seth, n	1.0.	3013	Flon	er Ave	. Silve	· Sprin	, /	71.	2050	3/
	State	31. Date filed (Month	1, Day, Year)	Reg	istrar's Signa	lure	1 -	4 1					

State of Maryland / Department of Health and Mental Hygiene 99

			Certificate of		Reg.	22	3/5/3
	Physic	30	Decedent's Name (First, Middle, Last)		2. Date of Deeth Month	Day Ye	3. Time of Death
	/Medi		Joyce Eunice Saunders		NOV		
)	Exami		4e. Fecility Name (If not institution, give street end number)	4b. City, Town, or Lo		4c. County of [Death
1	Funeral		MALCOLM GROW MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes		NGS 8. Date of Birth		GEORGE S
	Director		579-46-8516 1 M 250 F 63 Yrs. Montha De Usual Residence of Decedent	ys Hours Min.	(Month, Dey, Yea	,1936 W	Birthplace (State or Foreig Country) ashington, D
	with the Maryland a or 28a-f show De notfilled at	or.	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limit
	N 0 €	ecto	MD. Prince Georges Ft. Washington				
	No.	디	10e. Street and Number 10f. Zip Cod		10g.	Citizen of Whe	t Country?
	oth w	rai	6801 Bock Rd. #216 2074	•		USA	
020	within 72 hours eftar daeth with the Maryland ena. than "natural", or items 23a or 28a-f show na Medical Evam her must be notified a	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	of Hispanic Origin? (Spe uban, Mexican, Puerto I No Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc. Black
0-10	72 hours natural', dical Ex	ted	15. Decedent's Education 16a. Decedent's Usual Oc	cupation	16b	. Kind of Busine	
21215-0020	J within 7 jiena. r than "n	Completed	(Specify only highest grede completed) Elementary/Secondary (0-12) 12th (Give kind of work do life. DO NOT use rel Supervisor	ne during most of workit ired)		RAMC	
P	al Hygie other vent, II	O	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Meid		
Maryland	d 2 should be filed th and Mental Hyg 7 is marked othe traumatic event,	To Be	Joseph Haywood	Pauline E	i minima min		
2	should by and Menta	F	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Str.			ty or Town Ste	te Zin Code)
X	d 2 should be and traum						16, <i>Lip 0000</i> /
a)	f Haalt frem 2		Ellen Johnson/ Sister 419 Hayworth 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemelery, cremetory or other)				y or Town, Stale
Baltimore,	permit. Pagas 1 end 2 Department of Haalth a Important: If item 27 is any injury or other tra once.		1 △ Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) cremetory or other in the state of the s		-16-99 Ar	-	
Bal	Departition any in			's Funeral	_		
			23a. Itan1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart feilure. List only one ceuse on each line.	St. N.W.	Washingtor respiratory arrest	1, D.C.	20011 Approximate
	Physician /Medical Examiner	er	Immediate Ceuse (Final disease or condition resulting in death) a.RESPIRATORY FAILURE Due to (or as a consequence of):				Interval Between Onset and Death
Box 68760,	cartificate be axecuted nding physician and use as tha bunal-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.METASTATIC LUNG CANCER Due to (or as a consequence of): c.GASTRIC TUMOR Due to (or as a consequence of):				
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0	tha d	ıysı	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part 1.	23b. Did tobac	:co uae contrit	oute to the cause of death
9	that ed b	by Physician/			1 🔯 Yes	2 No 3	Probably 4 Unknow
Records,	law requires nes been sign a 2 should be	Completed			24a. Was an au performed		4b. Were autopsy findings aveileble prior to completion of cause of death?
	Tha law cata hes	00			1 ☐ Yea	25No	1 ☐ Yes 2 ☐ No
/ita	ysician: The s cartificata director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
of Vital	5 00	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Hon	ne 5 Residence	6 □Other (Specify)
Division c	To the Hospital or Attending Phyminia 24 hours aftar death. To the Funeral Director: Aftar thi compiataly filled in by the funeral	ation:	2 D Addidon	njury at 2 Vork? □ Yes 2 □ No	8d. Describe how In	njury occurred	
Divi	s aftar da il Direct	Sertific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	20	8f. Location (Street City or Town, St	and Number o lete)	or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After complately filled in by the fune	edical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in m and manner stated.	time, date and place, e y opinion, deeth occurre	nd due to the ceuse d at the time, date a	e(s) and menne and placa, end	r es steted. due to the cause(s)
	To the within To the comple	Ž	29b. Signeture and title of certifies 29c. Lice	ense number OH	29d. I	Date signed (M	fonth, Dey, Year)
	7		Monart Tomes 1110	07-034	1-1=1	/11/2 S	7 1999
	(m)	1	30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print 89 MD)			ROAD	1000
			THOMAS G. FRASER, CAPT, USAF, MC ANDRE	WS AIF FORC			2
	Sta Registr		31. Date filed (Month, Dey, Year) NOV 1 2 1999				

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State of Maryland / Department of Health and Mental Hygiene 99 375 | L

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2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 See. Place of Injury - At home, ferm, street, factory, office 5 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 3 3 5 5 6 6 6 7 7 7 7 7 7 7	0		Hospitel: 1 Inpa	itient 2 ER/Outp	atient 3 D	OA OH	er: 4 ⊟ 1¶	ursing Hor	ne 5 Resid	ience 8 🗆 Oth	er (Specil	fy)
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29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31 S 8 4 8 1 8 1 9 9			Physician: To the bes	st of my knowledge, d	eath occurred	et the ti	ne, date ar	nd place, a	and due to the o	cause(s) and ma	anner as s	stated.
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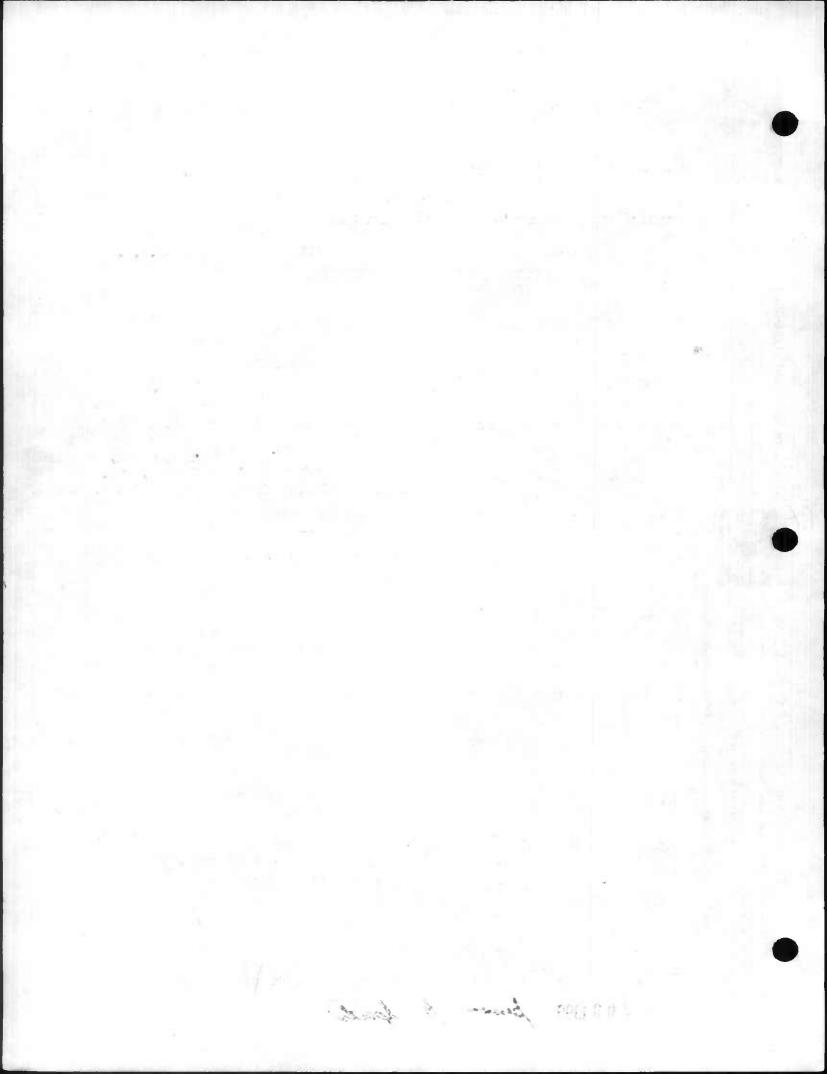
d				partment of Health and leartificate of Death	, ,	leg. No. 99	37515
	Physic /Medi		1. Decedent's Nam <i>e (First, Middle, Last)</i> Pauline E. Sullivan		2. Date of Dear Month Nov.	Dey Ye 7, 199	
	Funeral Director		4a. Facility Neme (If not institution, give street and number) Washington Adventist Hospital 5. Sociel Security Number 483 10 5683 Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's West Hy	Months Days Hours Min.	Park	4c. County of I Montgoi Year) 9. 1914	nery Birthplace (State or Foreign Country) Lowa 10d. Inside City Limits
0	72 hours after death with the Maryland natural', or ftems 23a or 28a-f show final Examiner must be notified at	Funeral Director	10e. Street and Number 3310 Pennsylvania Street 11. Maritel Status 1 □ Never Married 2 □ Married 1 □ Yes 2₹₹No	10f. Zip Code 20783 3. Was Decedent of Hispenic Origin? (S If Yes, specify Cuban, Mexican, Puert			tates American Indian, Vhita, etc.
d 21215-0020	d within piane. r than t	Completed by	Elementery/Secondary (0-12) College (1-4or 5+)	all Yes all No Specify: cedent's Usual Occupation five kind of work done during most of work by DO NOT use retired) memaker 10 Methodo Nos		Specify: 16b. Kind of Busine Own Home	·
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Baltimore,	permit. Pages 1 end Department of Health Important: If Item 27 any Injury or other tr once.			incoln Cemetery 22. Name and Address of Fecility Robert E. Evans Fu	neral Ho	ome, Inc.	d Maryland
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death) Due to (or es e condition resulting in death)	16000 Annapolis Rd enter the mode of dying, such as cardiac concey concey sequence on:	c or respiretory arm	Maryland est,	Approximate Interval Between Onset end Death
Box 68760,	laath certificata be executed attanding physician and I for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last b. COGN CONC. Due to (or as a constitution of the control o				
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Division	spital neral y fillec	edical Certification:	3 Suicide 4 Homloide 28e. Placa of Injury - At home, farm, building, etc. (Specify) 29e. Certifier (Check only only only only only only only only	eth occurred at the time, date end place	City or Town	n, Stete) ause(s) and menne	r Rural Route Number, r es steted. due to the cause(s)
	To the Ho within 24 h	Me	29b. Jonature end title of certifier	29c. License number D-33462	2	9d. Date signed (M	onth, Day, Year) -8, 1999
	Sta Registr		30. Name and eddress of person who completed cause of death (Item 23a) (Type Solve of the March 1997) 1997 1998	D-33482 Nover Parleway	Greenb	elt, Ma	1.20770

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99-6655-0 DDG UNK 99-20 (TINA MAI	Please Type or Print In Black Indelible Ink. Assure A State of Maryland / Department of Health and M	Mental Hygiene 99 37516
Physician	EM: #1 PER MEO G781 3-2-2000 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) TINA MARIE SANSBURY Sansbury	2. Date of Death Month Day Year NOVEMBER 6, 1999 2300 PM
/Medical Examiner	4a Facility Name (If not institution, give street and number) BALTIMORE WASHINGTON PARKWAY NORTHBOUND 4b. City, Town, or L JESSUI	ocation of Death 4c. County of Death
Funeral Director	5. Social Security Number 219-15-9641 6. Sex 1 Months 1	8. Date of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country) Mary Land
death with the Maryland ma 23a or 28s-f ahow created be notified at	Maryland Prince George's District Heights	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
If the death with the Ms from 23a or 28a-fa diner must be notified Funerral Director	10e. Street end Number 10f. Zip Code 20747	10g. Citizen of What Country? U.S.A.
5 22 5	11. Meritet Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried 1 Yes 2 No	pecify Yes or No- Plican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0020 d2 should be filed within 72 hours after that dwells they been. The marked other than "natural; or the traumatic event, the traumatic ev	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) N/A	16b. Kind of Business/Industry N/A
/jand uid be filled Wental Hygurked other ritic event,	17. Father's Name (First, Middle, Last) Robert Bruce Sansbury Marga	e (First, Middle, Maiden Sumame) aret Lee Harrison
Baitimore, Maryland 212 permit. Pages 1 and 2 should be filed with Department of thealth and Mental Hyglene. Important: If item 27 in marked other than eny Injury or other traumatic event, that price. To Be Comy	Robert Bruce Sansbury (Father) 6106 Alpine Street Di 20a. Method of Disposition 1XX Surial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland State Veterans Ce 21. Squatture of Father (Specify) 22. Name and Address of Facility Lees	strict Heights MD 20747 Date 2,1999 Cheltenham, Maryland Funeral Home, Inc. Ferry Road Clinton, MD 20735
Physician /Medical Examiner	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or respiratory arrest, Approximate therval Between Onset and Death
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P.O. d by the detacher	Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.	23b. Did tobacco use offitribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Records ne lew requires that been sign tge 2 should be		24a. Was an autopsy parlormed? 24b. Were autopsy tindings available prior to completion of cause of death?
Vital Indian: The certificate irector, pag	25. Was case reterred to medical examiner? 26. Place of Dea	1 10 Yes 2 No 1 10 Yes 2 No
Division of the Attending Physical Country and the threat of the tuneral of tun	Hospital:	ome 5 Residence 6 XX other (Specify) SCENE 28d. Describe how injury occurred Passense of motor vehicle That struck fixed objects. 28t. Location (Street and Number or Rural Route Number, Gly or Town, State) Ann. Arundel Co Mo
Hospi 4 hou Funer hely fill	29e. Certifier (Check only and) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, control of the basis of examination and/or investigation, in my opinion, deeth occur and menner stated.	and due to the cause(s) end manner as stated. red et the time, date and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of pertifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) NOVEMBER 7, 1999
(12)	30. Name and authors of parson was completed cause of death (tem 23s) (Type, Print) Pest we 111 Penn Street, Baltimor	re, Maryland 21201
State Registrar	31. Date filed (No. 1) Day, Year) 82. Registrar's Signature 9. Apacls	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death ELIZABETH MARY SOARES VOV 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BURNIE ARUNDEL L HOSPITAL

7. Age (In yrs. last birthday) NORTH GIEN If Under 1 Year | If Under 24 H 5. Social Security Number Dete of Birth (Month, Day, Year) Birthplace (Stale or Foreign Country) Days Months Hours 1 M 2 F 86 21,1913 Bermuda 216-51-7117 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. Anne Arundel Crofton 1 Yas 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 BERMUDA 1450 Vineyard Court 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: XX Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Store Manager retail 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Manuel J. DeFontes Angelina DeMoura 19a. Informent's Name/Relationship (Type, Print)
Sandra Barnhardt/ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) same as 10e 20b. Place of Disposition (Nama of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Nov. 6,1999 Huntt Crematory Waldorf, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Furnish Service Licenses 22. Neme and Address of Facility Robert E. Evans Funeral Home , Inc 16000 Annapolis Rd., Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that cellsed the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Finel 1DUN disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes ANO 3 Probably 4 Unknown 24b. Ware autopsy findings eveileble prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yas -20 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 28 No 2 ☑ ER/Outpatient 3 ☐ DOA

Examiner P.O. Box 68760, of Vital Records.

Physician/Medical Examiner To the Hospital or Attanding Physiolen: The law requires that the death certificate be executed within Ed. hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the turnest director, page 2 should be deteched for use as the burial-transit completely filled in by the turnest director, page 2 should be deteched for use as the burial-transit þ Completed 8 edicai Certification: To Division

Physician /Medical

Physician

/Medical

Examiner

10a State

Director

Funeral

Completed by

Be

2

Funeral

Director

aitimore, Maryland 21215-0020

DHMH 16 Rev 6/95

State Registrar

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature with till

29e. Certifier

5 Pending investigation

6 ☐ Could not be

32. Registrar'a Signature 0 8 1999

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

ed ceuse of deeth (Item 23a) (Type, Print) 4201 Mitchellville

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

28c. Injury at Work?

29c. License number

1 Yes 2 No

On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Pay, Year)

State of Maryland / Department of Health and Mental Hygiene

Physician	Decedent'e Name (First, Middle, Last)	1 1	Stario	50-	2. Dete of Dee Month	th Dey!	Year 19 Deeth
/Medical	4e Facility Neme (If not institution, give	street end number)	stones	4b. City, Town, or Lo	cation of Death	4c. County	of Death
Examiner				Randal1s			
Funeral Director	5. Sociel Security Number 6. Sec		s. lest birthday) If Under 1 Y Yrs. Months D	ear If Under 24 Hrs. eys Hours Min.	8. Dete of Birth Month, Pay 2/7/1	(27)	Birthplace (State or Foreig Country) MD
-f ahow	10e. Stete 10b. County	10c. C	City, Town or Location				10d. Inside City Limit
a or 28a-f ahow be notified at	MD Carr	:011	Westminster				1 N Yes 2 □ N
r Nems 23a or 28a-fa Nost mant be noutfed Funeral Director	10e. Street end Number 120 E. Green St., Apt. 2 10f. Zip Code 21158			1	10g. Citizen of W USA	/het Country?	
by by	11. Maritel Stetus 1 Never Married Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	U,S. 13. Wes Decedent If Yes, specify 1 ☐ Yes 2 🛣	of Hispenic Origin? (Spe Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race Bleck Specify:	e-American Indien, k, White, etc. white
ygiene. Net than "natur. nt, the Medical. Completed	15. Decedent's Education 16e. De (Specify only highest grade completed) (Gittellitte		16e. Decedent's Usuel O	Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
	Elementery/Secondary (0-12)	College (1-4or 5+)	Truck Driver			Animal Feeds	
arked other atic event, To Be Co	17. Fetner's Neme (First, Middle, Last) 18. Mother's No.				eme (First, Middle, Maiden Surname) Stonesifer		
27 is ma or trauma	19e. Informent's Name/Reletionship (Type, Print) Wilma Hollingshead , Daughter 19b. Melling Address (Street and Number or Ru 270 N.Gorsuch Road				ural Route Number, City or Town, State, Zip Code) Westminster, MD 21157		
tt if flem y or othe	20e. Method of Disposition 1X Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) John Luther Miller Cemetery 11/16/99 Westminster, MD						
Departm Importa any Inju	21. Signature of Funeral Service License	7 Settle	22. Name end A Little's	ddress of Fecility F.H. 34 Ma	ple Ave	. Little	estown, PA 173
Medical	Immediate Ceuse (Final disease or condition		Hemisph	_			Approximete Interval Between Onset end Deeth 3days
gphysician and set the burial-transit est be burial-transit edical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	e. Right Due to Due to	(or es e consequence of): (or es e consequence of): (or es e consequence of):	_			Interval Between
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104 15 1393 James G. Spenson

State of Maryland / Department of Health and Mental Hygiene 99 37519

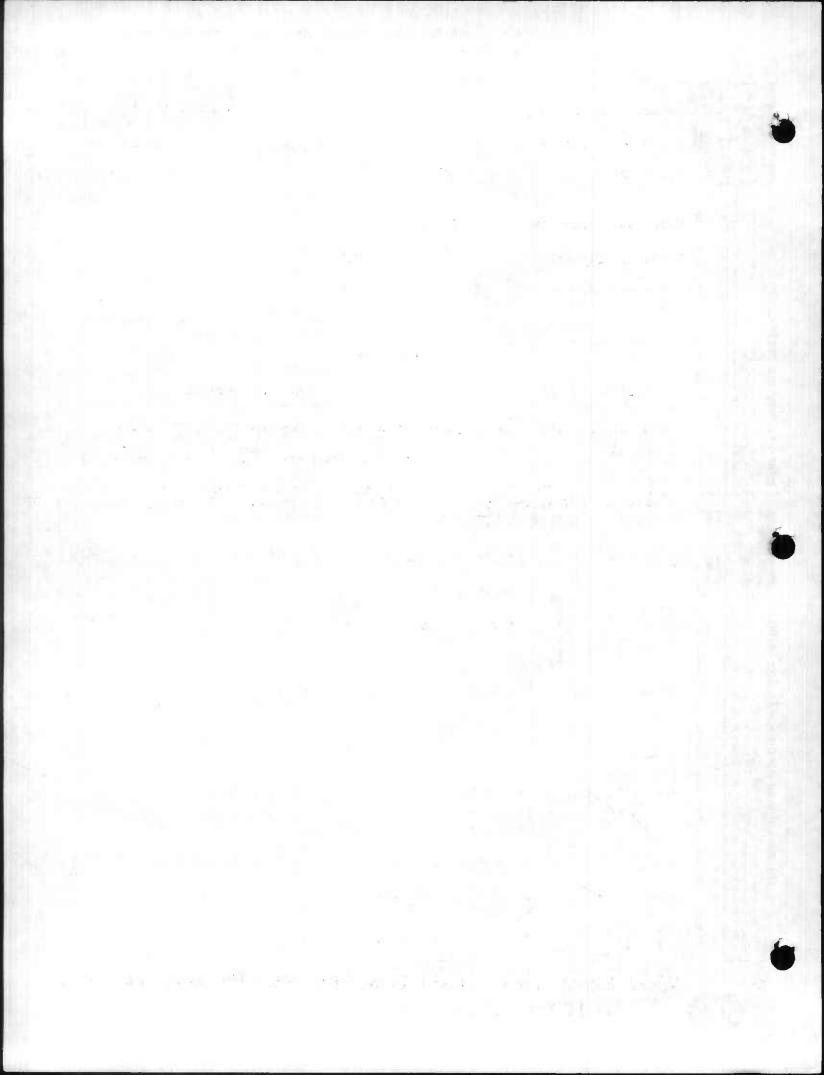
				Cert	ificate of	Death		Reg. No.	3 3 1 5 1 9
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	/Medical	61/6er7		ru	acr	4b. City, Town, or	IVOV	1/ /	799 1273 PM
	Examiner	4a Facility Neme (If not institution, give	sing Hom	0		(0/m	(6)	h 4c. County	C L C
	Funeral	5. Social Security Number 6. Se	7. Age (In yrs. les	t birthday)	If Under 1 Yeer Months Days	If Under 24 Hrs		th Voes	Birthplace (Stele or Foreign Country)
ш	Director	213-10-4079	XM 2□F 93	Yrs.	MOITINS Days	riouis mili	Nov 30	1905	Va.
	P	Usuel Residence of Decedent 10a. Stete 10b. County		Town or Loca					10d. Inside City Limits
	Mary to	Md Howard	d Elli	.cott (City				1 No 2 No
	after death with the Marylar or items 23a or 28a-f show iminar must be notified at	10e. Street and Number 3362A N. Chatham I	Road		10f. Zip Code 2104	2		10g. Citizen of W USA	fhat Country?
21215-0020	5 1 6	11. Merital Stetus 1 Never Merried 2 Merried 3 NWidowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 XNo H Yes, Give Year or Detes:		es Decedent of I Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		e - American Indian, k, White, etc. : white
15-0	"netural", ideal En	15. Decedent's Edu (Specify only highest grad		(Give ki	nt's Usuel Occup nd of work done	during most of wo	rking	16b. Kind of Bu	siness/Industry
121	withing within withing withing withing withing withing withing withing withing	Elementery/Secondery (0-12)	College (1-4or 5+)		NOT use retire			Western	Electric
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/lar	ahould be nd Mental marked o urmatic eve	Richard Lee Strud	er			Lola Ba	rr		
2	and 2 aho eith and ? 27 ie ma er trauma	19e. Informent's Name/Relationship (7) Harry G. Struder		_		and Number or Re Rd., La			
_	emit. Pages 1 epartment of He moortant: If han ny injury or oth-	20e. Method of Disposition 1 Burial 2 Cremetion 3 F 4 Donation 5 Other (Specify)	Removel from Stete 7.11	netery, creme	tion (Name of htory or other ple Cremat		Dete 1-12-99	20c. Location · Sykesvil	City or Town, State
Bail	Departition of the popular of the po	21. Signeture of Funeral Service Licens Parge Haight			Neme end Address D. Box 1	95 Sykes			ome & Chapel
		23a. Pert1. Enter the diseese, or composhock, or heart feilure. List only o	lications thet caused the deeth. ne cause on each line.	Do not enter	the mode of dyi	ng, such es cardie	c or respiretory a	rrest,	Approximete Interval Between
	Physician /Medical Examiner	Immediete Cause (Final disease or condition	Relunous	15 7	Libra	ris			Onset end Deeth
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of	1 5 5 F	1 Yes 2 No	1	VOutpatient	3LI DOA		T	dence 6 □Oth	
E 8	D FE CO	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Dete of Injury (Month, Day Year)	8b. Time of Injury		ryat rk? Yes 2□No	28d. Describe	how injury occurr	ed .
Divi	is aftar al Dirac led in by	4 Homicide determined	28e. Plece of Injury - At home building, etc. (Specify)				City or To	wn, Stete)	er or Rural Route Number,
2	in 24 hours he Funer pletaly fill	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examinetion and manner stated.	edge, death on end/or inve	occurred at the ti stigation, in my o	me, date end place opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) end me date end place, a	nner as stated. and due to the cause(s)
	Mer Mer	29b. Signature end title of certifier	3		29c. Licens	se number		29d. Dete signed	1 (Month, Dey, Year)
	> 0	Hay Kon	50 mo		174	1617		Nov	11 1599
		30. Neme and address of person who co	impleted ceuse of death (Item 2:	3a) (Type, Pr	rint)	1111	1		
		Gary KAZIOW	10805 Hickor	5 Ric	15 E R	d (de	instig i	md Cl	045
	State Registrar	31. Date filed (Month, Day, Year) NOV 1 2 19	32. Registrer's Signeture	4	10-				

from G. doaler

50815 L VOV

State of Maryland / Department of Health and Mental Hygiene 99 37520

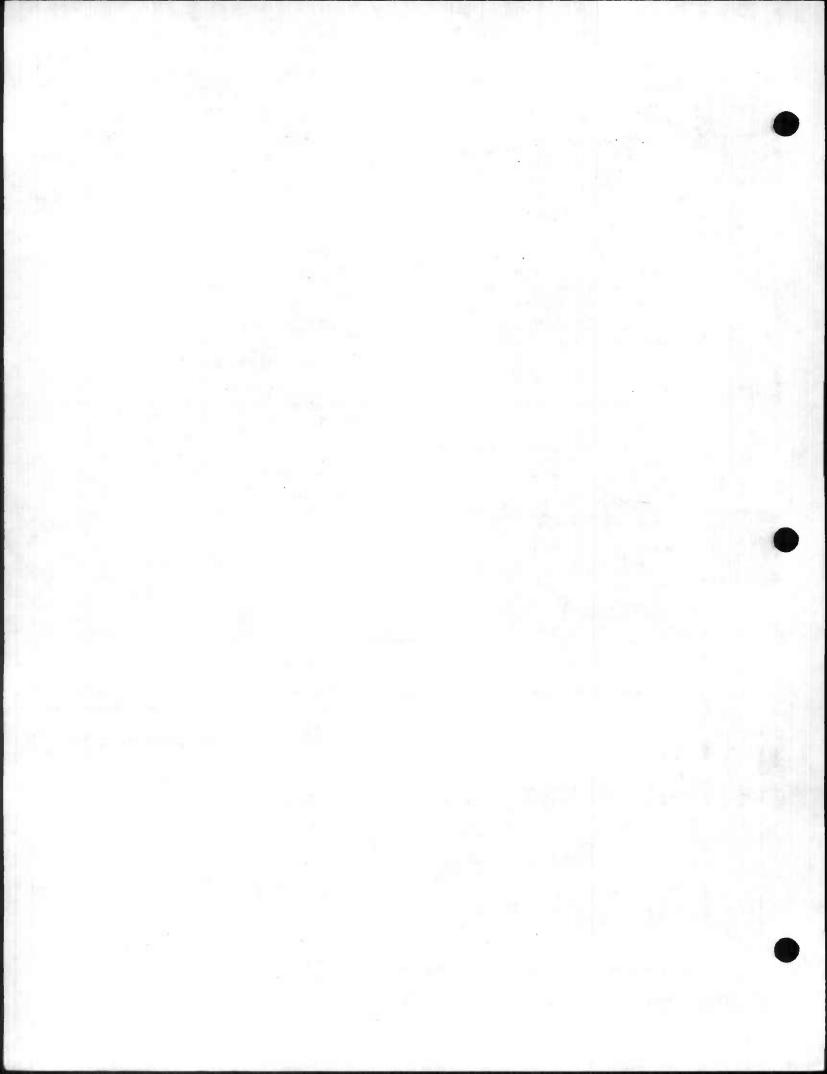
				Cert	tificate of	Dealli		Re	g. No.		1360
	1. Decedent's Name (First, Middle	, Last)					2.	Date of Deetl	Day	Yeer	3. Time of Deeth
hysician /Medical	Dolores Lucille	Shepard					N	Vovembe			10:29 am
Examiner	4a Facility Neme (If not Institution	, give street end numbe	r)			4b. City, To	wn, or Locat	tion of Death	4c. County	of Deeth	
	Montgomery Gene	ral Hospita	1			Olney			Montg	omery	
uneral	5. Social Security Number		Age (In yrs. las		If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth			lece (State or Foreig
rector	178-09-8242	1□M 2ØF	89	Yrs.				(Month, Day,	1910		sylvania
ž	Usual Residence of Decedent 10e. State 10b. County		10c. City,	Town or Loc	ation					1	Od. Inside City Limits
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uner	1 Never Merried 2 Marri	Armed Forces	?		/as Decedent of Yes, specify Cu			an, etc.)	Bla	ck, White,	etc.
leted by F	3 Widowed 4 □ Divorced	H Yes Give		1	☐ Yes 2 No	Specify:			Specify	v: Whi	te
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To B	Dan Larimer					Pear	1 .I. I	Jnknown			
T T	19e. Informant's Name/Relationsl	hip (Type, Print)		19b. Mailing	g Address (Stree					Stete, Zip	Code)
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r other tra	Teresa L. Shepa 20a. Method of Disposition	ru/ Grandda	20b. Plac	ce of Dispos	sition (Neme of	LAVE	ine, t	Date 2	20c. Location	- City or To	wn, State
5	I Doller Zactoremation	3 LINGING WEI HOITI STAT			tan Crei		110	1 10 1	lexand		VΔ
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cian							,				Onset and Death
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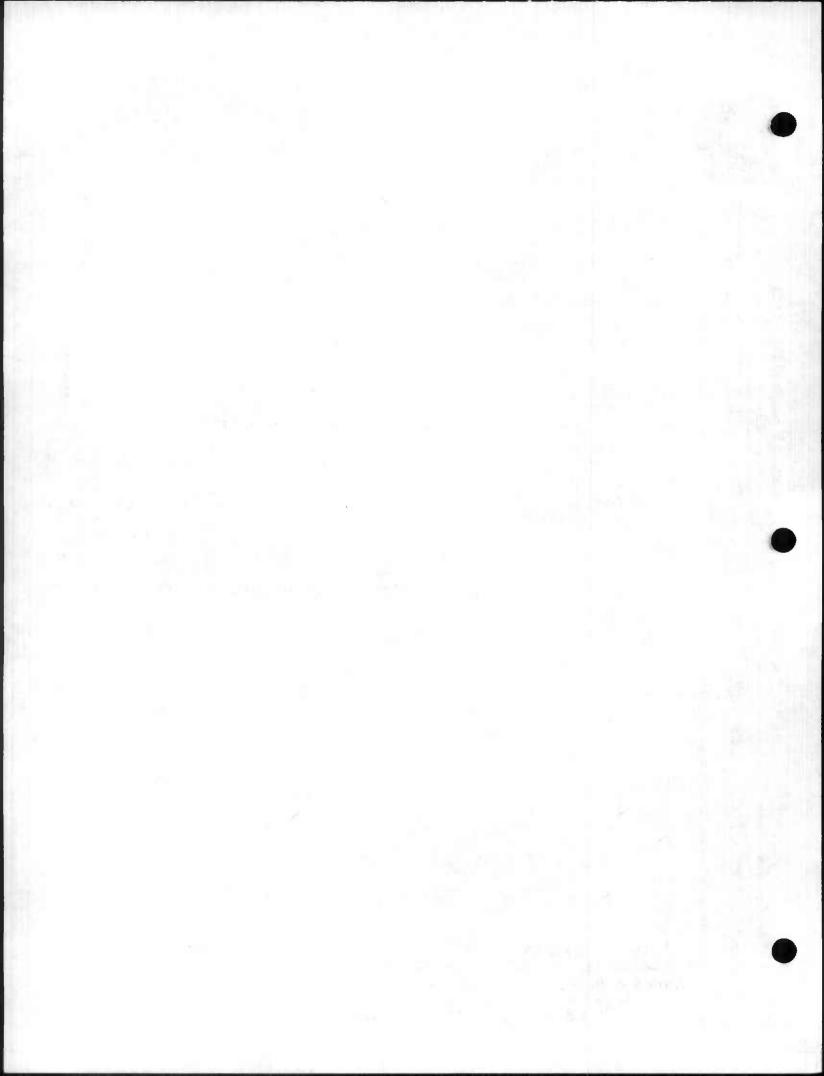
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1 Decedeals Name (First Addust 1	-Al		Certific	ate of	Death		Reg. No.	9 3/5	41
Decedent's Neme (First, Middle, La						2. Dete of De Month	Day	Year 3. Time of	
HELEN SCHMELT 4a Facility Name (If not institution, giv					4h City Town	11.16		2:25	PM
SUBURBAN HOSP					BETHE		,	GOMERY	
5. Social Security Number 6. S		e (In yrs. last i	Mont	nder 1 Yea	r If Under 24 h			9. Birthplace (State of Country)	or Foreign
102.05.1186 Usuel Residence of Decedent	ILIM ZAIF	82	Yrs.			10.22.	1917	NEW	YORK
MD 10b. County MONTGO	MERY		wn or Location KVILLE					10d. fnside Ci	,
10e. Street end Number 6111 MONTROSE RO	AD #725		10f.	Zip Code	20852		10g. Citizen of V USA	What Country?	
11. Marital Stafus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:			ecedent of specify Culture 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		(Specify Yes or No ento Rican, etc.)	14. Rac Blac Specify	ce - American Indian, ck, White, etc. WHITE	
15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16	Give kind of	Usuel Occu f work done	upation e during most of ed)	working	16b. Kind of B	usiness/Industry	
Elementery/Secondery (0-12)	College (1-4or 5	5+)	HOMEM		00)		OWN H	OME	
17. Father's Name (First, Middle, Last)						Neme (First, Middle		ne)	
WILLIAM STERN						IE FUTTER			
19e. Informent's Neme/Retetionship (SHARON BLOCK SCH	*, .					Rural Route Numb			
20a. Method of Disposition 1 Burial 2 Cremetion 3 X	есе)	Dete	20c. Location -	City or Town, Stete					
4 □ Donetion 5 □ Other (Specific	y)	BETH	EL CEM					OD, NEW JE	RSEY
21. Signeture of Funeral Service Licer						RAL DIREC			0852
Immediate Causa (Final disease or condition resulting in death)	b	Due to (or es	e consequence	of):	ry Dise	ase	- 3	yea	rs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	c		a consequence			*			
Part II. Other significant conditions of	ontributing to death by	ut not resulting	In the underlying	ng cause g	iven in Pert I	23h Did	tohacco use co	ntribute to the cause of	of death?
The state of the s	onthoding to death of	or not resulting	in me uncerry	ng cause g	IVOIT ST FOILT.		Yes 2 No	3 Probably 4	
							en eutopsy ormed?	24b. Were eutopsy f aveilable prior f completion of c of death?	o
						10	Yes 2 XNo	1 ☐ Yes 2	No
25. Was case referred to medical examiner?	Hospitel:			10		Deeth (Check only	one)		
1 Yes 2 No	28a. Dete of Injur (Month, De)		Outpatient 3 Time of	DOA		g Home 5 Resi	dence 6 Oth		
1) Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined			Injury M	1[ury at ork? ☐ Yes 2 ☐ No			ber or Rural Route Num	nber.
Uniform building, etc. (Specify) City or Town, State)									
(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cau end menner steted.								anner as stated. and due to the cause(s	i)
I found Horden mo D47791 Nov							Vovember	d (Month, Day, Year) - 17, 1999	
30. Name and address of person who o	completed cause of de	eeth (Item 23a	(Type, Print)	le.	Marula	and Zo	851		
31. Date filed (Month, Day, Year)		er's Signeture		-	1				



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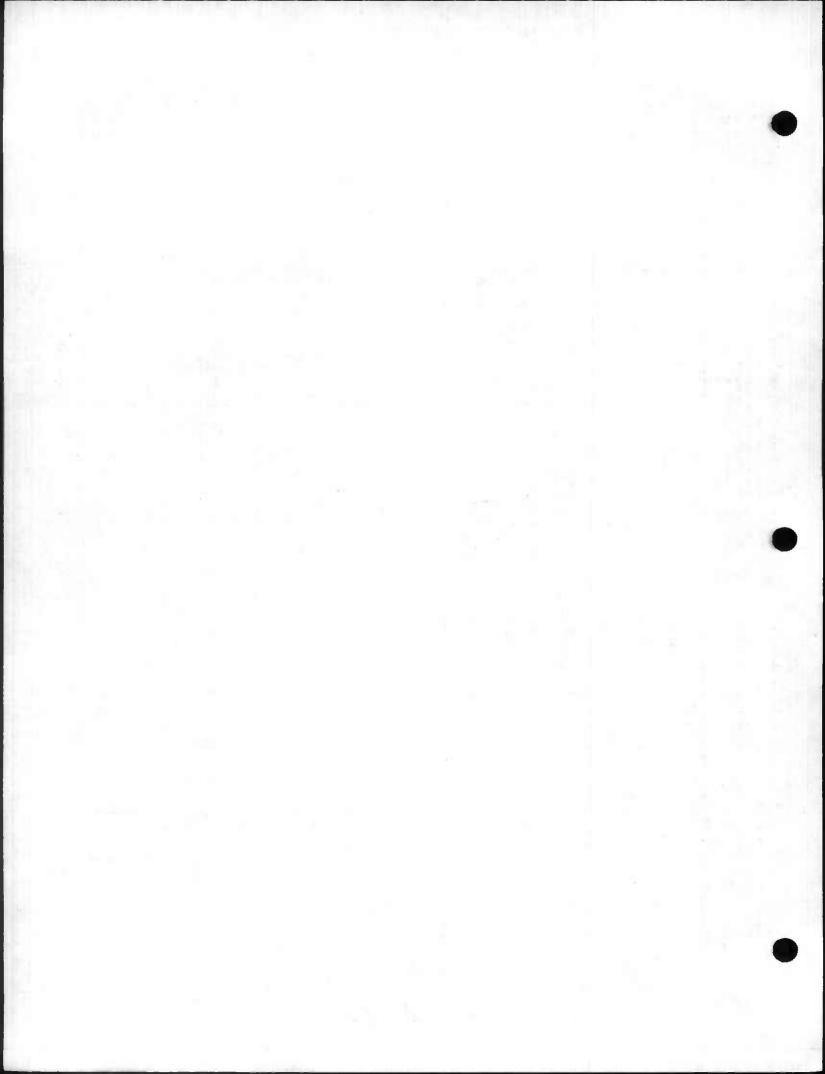
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П	Physicia	\n	1. Decedent's Name	(First, Middle, I	Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	_	Morris	Seltz	er					1000000	er 16,	11-20-	8:30 pm
1	Examin		4a Facility Name (II	not institution, g	give street and numb	er)			4b. City, Town, or L	ocation of Death	4c. County	of Death	•
8		Ш	Bedford C			e			Silver Sp	ring	Montg	omery	
	Funeral		5. Social Security N	umber 6	Sex 7.	Age (In yrs.	last birthd		If Under 24 Hrs.				ace (State or Foreign
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	show	_	TOB. Stete	10b. County		10c. C	ty, Iown o	r Location				10	od. fnside City Limits 1 ☐ Yes 2 ☑ No
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		by Funeral	11. Meritel Stetus		12. Was Decede Armed Force	957	J,S. 1	Wes Decedent of I If Yes, specify Cut	Hispanic Origin? (Sp van, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
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8	n 72 hours natural',		3 Widowed		Year or Date	s:							
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altimore,	00- 5		20a. Method of Disp 1 ☐ Buriel 2X		☐Removel from Ste	200. I	cem <i>etery</i> ,	sposition (Name of crematory or other ple	ice)	Nov 17	ZUG. LOCATION -	- City or To	vn, Stete
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L C	After fune	Ö	1 Naturel	5 Pending investigati	(Month,	Day Year)	Inju	y Wo	ork?]Yes 2 □ No	200. 2000/2011	on anjuly occur	100	
Division of Vital Records,	al or Attending Pi s after deeth. I Director: After it d in by the funera	Certification:	2 Accident 3 Sulcide	6 Could not	ho	Inlune At h	ome form			28f. Location (S	troot and Numi	har or Bure	I Route Number
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		_	29b. Signature and t	itle of certifier	and menner	atotisti.		29c. Licen	se number		9d. Date signe	ed (Month I	Day, Yearl
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			30. Name and eddre	ss of person wh	o completed cause of	of death (Iter	n 23a) (Ty	pe, Print) USUM (WONL)	RLUI) CI	LIPH CO	nine m	0 24	906
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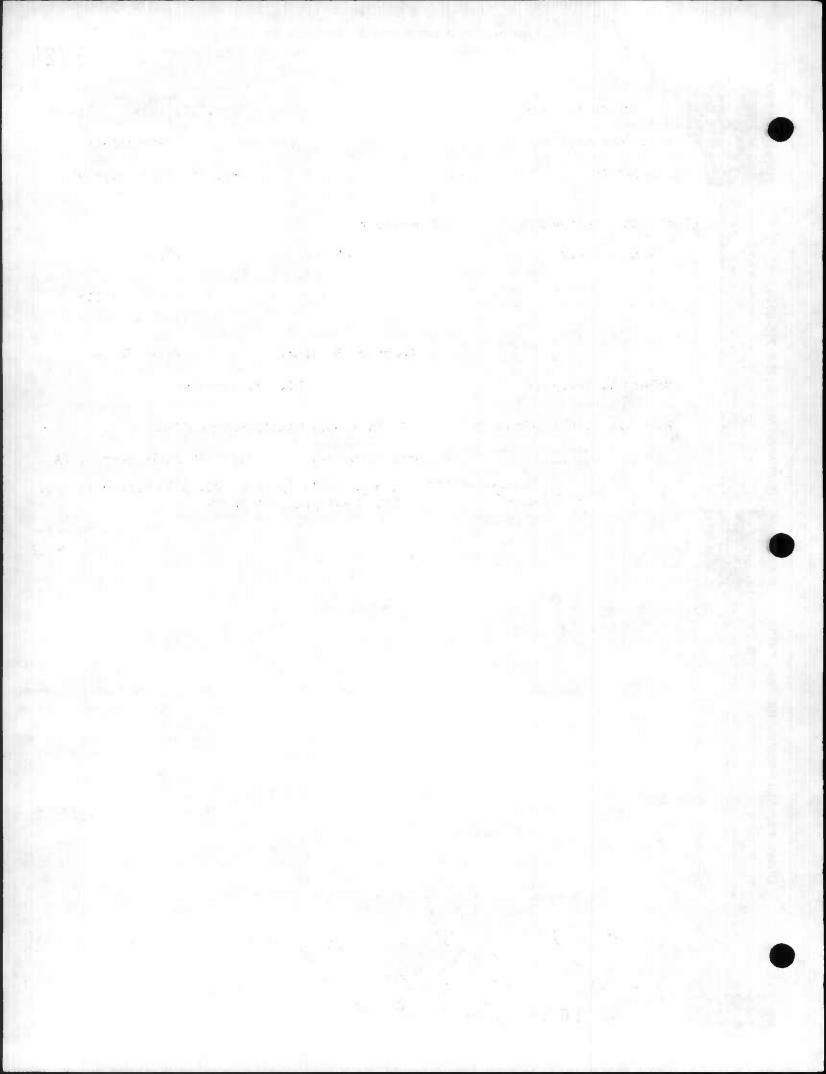
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Dhyeician		ent's Nama (First, Midd	123217						į.	2. Date of Deat Month	Day	Year	3. Tima of Dea
Physician /Medical		ROBERT	SHERD							NOV. 12	,1999		2:35am
Examiner	4a Facilit	y Nama (If not Institution MARINER C	100				4		wn, or Loc ETHES	ation of Death	4c. County MON	of Death	RY
Funeral Director		Security Number 4–20–6350	6. Sax 3√ M 2 ☐ F		rs. last birthday 6 Yrs.	Months	1 Year Days	If Under Hours	Min.	B. Data of Birth (Month, Day, July 9,		9. Birthp	olace (Stata or For
	_	sidence of Decedant								7 - 1			
r 28a-f show Indthed at rector	10a. State	10b. County	NA	100.	City, Town or L	NGTON						1	0d. Inside City Li
or 28	10e. Street	et and Number				10f. Zip 0	Code			1	g. Citizen of \	What Cour	ntry?
23a mtb	220	Florida A	venue, N	. W.			2	0001			Unite	ed St	ates
or Items impac.m	11. Marite	Il Status evar Married 2 Mar	Armed 1 Ya If Yas,	ecedent Ever in Forcas? is 2 12No Giva r Datas:	U,S. 13.	Was Decede If Yes, specif 1 ☐ Yes 2			gin? (Spec n, Puerto R	ify Yas or No- ican, atc.)	14. Rad Blad	ck, Whita, y: Bla	can Indian, atc.
is and Mental Hygiane. Is marked other than "natural", or raumatic event, the Wades Emen To Be Completed by F		15. Deceder	nt's Education		16a. Dece	edent's Usual	Occupa	ition			16b. Kind of B	usiness/Inc	dustry
	Eleman	(Specify only highantary/Secondary (0-12)	1	ed) e (1-4or 5+)	(Give	e kind of work DO NOT use	k done d e retired)	luring most)	t of working	9			
dien in in		7th				Restau	ıran	t Wor	ker		Privat	te In	dustry
d other event, a	17. Fatha	r's Nama (First, Middle,	Last)							(First, Middle, A			
f Health and Mental Hygiene. from 27 is marked other than other traumatic event, the M To Be Compl	Rok	ert Sherd						Eron	na Bes	st			
N Due		mant's Name/Ralations	ship (Type, Print)		19b. Mail	ing Address ((Street a	and Numbe	er or Rurat	Route Number	City or Town,	State, Zip	Code)
alth e 27 is or tra	Cle	eo Lee - Si	ster		8405	10th A	Aven	ue, s	Silve	r Sprin	. MD 3	20903	
f Health item 27 other to		od of Disposition			. Place of Disp cematery, cre	osition (Name	e of				20c. Location		own, Stata
0 = 9		Burial 2 XCrametion Donation 5 ☐ Other (S			hesarea			•	11	1/17/99	Green	nbelt	, MD
Departmentimportant:	21. Signe	tura of Funarel Sarvice	Licensea			2. Nama and							
SESS		Dr.	7.7							orticia:			
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ding physician end se as the bunal-transit	rasuring	ally list conditions, ding to immediata nter Undarlying isease or injury ed evants in death) Last	c	Dua to	(or as a conse	quence of):							
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gned by the attending physicial be detached for use as the but by Physician/Medical	Part II. Ot	in death) Last	c	Due to	(or as a conse	rquence of):	usa give	on in Part I.			autopsy	3 Pro	bebly 4 Unk
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deeth. too: After this certificate has been signed by the attending physicia y the funerel director, page 2 should be detached for use as the but l'cation: To Be Completed by Physician/Medical	Part II. Ott	tasa rafarrad to medicanar? as 2 No ar of Death atural 5 Pandir coidant Invasti uicide 6 Could datarr tier 2 Medical	Hospital: 1 28a. Dat (M. (M. (M. of M. of	Due to Due to Due to death but not not not not not not not not not no	(or as a consector of a consector of as a consector of a con	quence of): quenc	A Other C. Injury Work 1 1 1 office	26. Place C ASNu at r fes 2 1	of Death principle of Death 26 No 26 d place, arthocourred	1 Ye 24a. Was an perform 1 Ye (Check only on a 5 Reside 3d. Describe ho if Location (St. City or Town	autopsy ned? s 2 No n autopsy ned? s 2 No e) noce 6 Oth w injury occur reet and Numb, State) use(s) and mata and place, od. Data signe	3 Proid 24b. W. av co of 1 [that (Specifited annar as s and due to ad (Month,	bably 4 Unk ara autopsy findir allable prior to mpletion of cause death? Yas 2 No y) at Route Number, tated. b the cause(s) Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 99 37524

			Ce	ertificate	of D	eath		Reg.	No.		
	1. Decedent's Nama (First, Middla, Las	t)	1911				2. Date	of Death			3. Time of Death
Physician	Steven Allen	Shinn					Monti	. 11.	Day 1999	Year	:40PM
/Medical	4a Facility Nama (If not institution, give				4b.	. City, Town	, or Location of		4c. County		4UFM
Examiner	6209 Robinwood R					Beth					
	5. Social Security Number 6. Sec		yrs. last birthday) If Under 1	1 Year	If Undar 24		of Birth		gomery	
eral ctor	216-68-1886	M 2□F 45		Months			Min. (Mont				e (State or Forei
01	Usual Residence of Decedent	4.					Jan.	20,	1954	Maryl	and
	10a. State 10b. County	100	. City, Town or L	ocation						10d	. Inside City Limi
rector											1⊠Yes 2□N
Directo	Maryland Montgom	ery (Saithers		0.4.			40-	020	10	•
ä	10e. Street and Number			10f. Zip (What Country	1
2	22 Anna Court			20	877			U.	S.A		
Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13.	Was Decede	ent of Hisp by Cuban,	panic Origin , Mexicen, F	n? (Specify Yes of Puerto Rican, etc.	or No-		e - Amarican ck, White, etc	
正	1 Never Married 2 Married	1 ☐ Yes 2 🔼 No If Yes, Give	-	1□Yas 2	25	Specify:			1	Whit	
by	3 ☐ Widowed 4 ☐ Divorcad	Year or Dates:		100 2	22.110	opouny.			Specify	y. WILL.	
Be Completed	15. Decedent's Ed	ucation	16a. Dece	edent's Usual e kind of work DO NOT use	Occupati	ion	Luncking	16	b. Kind of B	usiness/Indus	stry
ple	(Specify only highest gra-	College (1-4or 5+)	life.	DO NOT use	e retired)	iring most o	working				
E	Elaman, Josephan, (6 12)	2	Com	puter	Engi	neer		W	lells	Fargo	
0	17. Father's Name (First, Middle, Last)				1	18. Mother's	Name (First, M	iddle, Mai	iden Suman	ne)	
0	Robert L. Shipp					Liza	A. Aiva	azian			
70	19a. Informant's Name/Relationship (7	ima Printi	10b Mail	lina Addraes	(Street as	nd Number	or Rural Route N	lumber C	ih or Town	State 7in C	ode)
											0007
	MIchelle A. Ship		0b. Place of Disp			Gait	hersburg			City or Town	Ctata
	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐		cemetery, cre	ematory or oth	her place)					
	4 ☐ Donation 5 ☐ Other (Specify		lational	Crema	tory		11/17	/99 F	alls	Church	, VA
	21. Signature of Funeral Sarvice Licen	see		22. Name and	Address	of Facility			00		
any injury or other tra	1166			_			Sons IN		30 W1	sconsi	n Ave.
	32a Parts War the disease or come	digations that assumed the	denth Donat of	W. Was	hing	ton,	DC 2001)		Α.	pproximate
n	23a. Part1. Ther the diseasa, or composhock, or heart failure. List only	one cause on each line.	oodiii. Do ilot oi	1101 1110 111000	or cynng,	, 30011 03 00	iralac or raspiral	ory arroot		lr.	iterval Between
_	Immediate Course (Final	1									~ (
	Immediate Cause (Final disease or condition resulting In death)	" [Yw	bho,	ma						Ox	te Rel
	resulting in death)	Due	to (or as a conse	equence of):							
ne ne		h								1	
Examiner	Sequentially list conditions,	Due Due	to (or as a conse	quence of):							
	if any, leading to immediate cause. Enter Underlying										
edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C. Due	to (or as a conse	quence of):							
ledicai Examir	resulting in death) Last			,						i	
3		d									
<u>S</u>				72.72				51444			
by Physician	Part II. Other significant conditions co	intributing to death but no	resulting in the	underlying ca	use given	n in Part I.	23b		cco use co		he cause of deat
P								1 Yes	2000	3 Probal	bly 4 Unkno
by										1 04 111	
Completed							24a.	Was an a performe	d?	availa	autopsy findings able prior to
ple							_			of de	oletion of ceuse ath?
E								1 ☐ Yes	2X No	100	res 2□ No
	25. Was case referred to medical				- 7	26 Place ~	f Death (Check		5.657.57		
o Be	examiner?	Hospital:	2 □ E0/0-+*	ant all no	Other		Committee Contract		· · X	ner (Specify	Parents
1: To	27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatie		Α	4 LI Nurs	ing Home 5 28d, Des		injury occur	red (Specify)	lome
Pol	1 XNatural 5 ☐ Pending	(Month, Dey Yea	ir) Injury	м	Bc. Injury a Work?	? es 2□No	-		,,		
Ca	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		AA baara (aasa a			03 2 2 110		ion (Etro	at and Mount	har or Dural C	Zouto Alumbar
Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At nome, farm, s pecify)	treet, factory,	office			or Town, S		oer or Hurai F	Route Number,
ပီ						-					
edical	29a. Certifier 1 Certifying Phy	rsician: To the best of my iner: On the basis of exer	knowladga, dea	th occurred a	t tha tima	, data and	placa, and dua to	the caus	se(s) and m	anner as stat	ed.
8	one)	and manner stated	1 // and or i	ivestigation,	ar my opi	mon, death	occurred at the	iiiie, date	and place,	and due to ti	10 0000(3)
Σ	29b. Signatura and title of certifier	101	1	29c.	Licensa	number	. (29d	. Date signe	ed (Month, Da	y, Year)
) //	/ nu	1	6	12/2	CX	X	No	Lande	115	10199
	20 Name and attended /	Louis	//am 00-1 /T	Delecti	100	100	0 1		-	W/	111
	30. Name and address of person who o	ompleted cause of death	(Item 23a) (Type	, Print)	V	000-	11/	()		min	N 2 C3
	devela!	1/100 1,	NIR	111	4)	1 10	1 41.11	V	1.	1	0011
State	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	1	- 1	/					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg No. 99 3752

												leg. No. 💆 "		
Physicia		ent's Neme (First,	, Middle, Las	st)							2. Date of Dea Month	th Day	Year	3. Tima of Dea
Pnysiciai Medica	€ CT	lon	Sc	cott		Shre	eve				Novembe	r 17, 1		5:50
Examine	4 - 5 - 100	/ Name (If not ins	stitution, give	street and nu	mber)			4	4b. City, To	own, or Lo	cation of Death	4c. Count	y of Death	
	Subu	rban Hos	spital						Bet	hesd	a	Mon	tgome	ery
Funeral	5. Social	Security Number	6. S		7. Age (In yrs.	. last birthday	// If Under	1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)			lace (Stata or Fo
Director	276	24 2031	. 1	₩ 2□F	69	Yrs.	WORKES	Days	110013	10001.	Aug. 30,	1930	Canto	on, Ohio
9		sidence of Deced			1									
aryle ahov	10a. Stet					ity, Town or L							1	0d. Inside City Li
the Maryler 28a-f show notified at	Mary	land Mon	tgomer	су	Ве	thesda	a							1 Tes 24
be filed within 72 hours after death with the Maryland tal Hygiene. I dother than "natural", or frams 23a or 28a-f show event, the Madical Examinar must be notified at	Mary 10e. Stre	and Number					10f. Zip	Code			1	0g. Citizen of	What Coun	itry?
23a	7002	Braebur	n Cou	rt			20	0817-	-4904			United	Stat	es
thems Darim	7002 11. Merito	l Stetus		12. Was Dece Armed Fo	edent Ever in U	J,S. 13.	Wes Dece	dent of H	lispanic Or an. Mexica	igin? (Spe	cify Yes or No- Rican, etc.)	14. Rae	ce - Americ	
of the state of	10N	ever Merried 20		1 [X] Yes If Yes, Giv	2 No		1 Yes					344	y: Whit	
A LA I D-UUAU within 72 hours aft jene. Than "natural", or the Midfall Exam	_ ,	idowed 4 Div	vorced	Yeer or D	etes:				Оросиј			Specif	y. WILL	
72 h	Elemen	15. De	cedent's Ed	ucation de completed)		16a. Dec	edent's Usu	at Occup	ation	at of worki	na	16b. Kind of B	Business/Inc	dustry
within she.	Elemen	tery/Secondery (0		College (1	1-4or 5+)	life.	DO NOT u	se retired	d)					
filed with Hygiene. ont, the	Ö	12		5+		Bran	ch Ch	Lef				Federal		rnment
be filed of other count, I	o 17. Fatha	's Name (First, M							18. Moth	er's Name	(First, Middle, I	Maiden Surnai	me)	
Menid	o Char	les Alvi	n Shr	eve					Fr	ances	Nelson	1	117	
Mar ylario 42 should be file h end Mental Hy 7 is marked othe trsumatic event.		ment's Neme/Rel	letionship (7	ype, Pnint)		19b. Mai	ling Address	(Street	and Numb	er or Rura	I Route Number	r, City or Town	, State, Zip	Code)
end alth	Ann	e Jo Sh	reve			7002	Brael	urn	Cour	t Bet	hesda.	MD 2	0819-	4904
Set Hora		od of Disposition Juriel 2 Dicrem		Demoved from		Place of Disp cemetery, cre	position (Nei	ne of other plea	ce)	t	Data	20c. Location	- City or To	wn, State
Dallimore, bernit. Pages 1 er Pepariment of Hea mportant: If Item; my injury or other ance.		onetion 5 Ot				esapea	ke Cr	emat	orv	1	1/18/99	Beltsvi	11e.	MD
프를로를				1	1					vRapr	Funera	1 &Crei	matio	n Servic
B E 8 8 7 7 78	21. Signe	ture of Funerel Se	ervice Elceni	500		2	LL. ITEITIO EU						III L L L U I	
Depariment any ir	21. Signe	ture of Funerel Se	ervice Elcent	500						Ster	phen D.	Lohrma	nn. P	.A.
permit. Pages 1 and 2 should be file. Department of Health and Mental Hy important: if itsm 27 is marked oth any injury or other traumatic event pages.	23a. Per	1. Entar tha disea	ase, or comp	plications that c	M009	56 9:	33 Gis	t Av	venue	Step , Sil	hen D. Lver Spr	Lohrma	nn. P	.A. 0910
	23a. Per	for 1	ase, or comp	plications that c	aused the dee	56 9:	33 Gis	t Av	venue	Step , Sil	hen D. Lver Spr	Lohrma	nn. P	.A. 0910 Approximate Interval Betwee
Physician /Medical	23a. Per sho	1. Entar tha diseack, or heart feilure	ase, or comp	plications that come cause on e	aused the dee ech line.	56 9: th. Do not en	33 Gis	st Ar le of dyin	venue ng, such es	Ster , Sil	ohen D. Lver Spr r respiretory em	Lohrma ing, M est,	nn, P	. A . 0910 Approximate Interval Betwee Onset end Dea
Physician	23a. Per sho	1. Entar tha diseack, or heart feilure	ase, or comp	plications that come cause on e	aused the dee ech line.	56 9: th. Do not en	33 Gis	st Ar le of dyin	venue ng, such es	Ster , Sil	hen D. Lver Spr	Lohrma ing, M est,	nn, P	. A . 0910 Approximate Interval Betwee Onset end Dea
Physician /Medical Examiner	23a. Per sho	1. Entar tha diseack, or heart feilure	ase, or comp	plications that come cause on e	aused the dee ech line.	56 9: th. Do not en	33 Gis	st Ar le of dyin	venue ng, such es	Ster , Sil	ohen D. Lver Spr r respiretory em	Lohrma ing, M est,	nn, P	. A . 0910 Approximate Interval Betwee Onset end Dea
Physician /Medical Examiner	23a. Per sho	1. Entar tha disea k, or heart feilure a Cause (Finat r condition n deeth)	ase, or compe. List only o	plications that come cause on e	aused the dee ech line.	56 9: th. Do not en	33 Gis	st Ar le of dyin	venue ng, such es	Ster , Sil	ohen D. Lver Spr r respiretory em	Lohrma ing, M est,	nn, P	. A . 0910 Approximate Interval Betwee Onset end Dea
Physician /Medical Examiner	23a. Per sho	1. Entar tha disea k, or heart feilure a Cause (Finat r condition n deeth)	ase, or compe. List only o	plications that come cause on e	aused the dee ech line.	56 9: th. Do not en	33 Gis	st Ar le of dyin	venue ng, such es	Ster , Sil	ohen D. Lver Spr r respiretory em	Lohrma ing, M est,	nn, P	. A . 0910 Approximate Interval Betwee Onset end Dea
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State of Maryland / Department of Health and Mental Hygiene 37526 Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 11 13 1999 BELLA 1:35 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 10/3/1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1□M 20F 78 Yes. WASHINGTON, D.C. Director 577-24-5356 Usual Residence of Dacedant 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Y Yes 2 No Director MONTGOMERY ROCKVILLE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 20852 6121 MONTROSE ROAD USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yas, Giva
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No 3 Widowed 4 Divorced WHITE 15. Decedant's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the filed within 7 antei Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 U.S. GOVERNMENT SECRETARY LIBRARY OF CONGRESS 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Heelth and Mantel Hy important: if Nem 27 is marked oth any linjury or other traumatic event page. Be LUBA RATNER MORRIS DAVID KAPLAN 19a. Informant's Name/Raietionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) JEANNE LEVIN/SISTER 5105 BENTON AVENUE BETHESDA, MARYLAND 20814 20b. Place of Disposition (Name of cematary, crematory or other place) Date 11/15/99 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Ď Burial 2 ☐ Cramation 3 ☐ Removal from State FALLS CHURCH, VA 4 ☐ Donetion 5 ☐ Othar (Specify) KING DAVID MEMORIAL GARDENS 21. Signeture of Funeral Sarvice Licenses 22. Nama and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) · Ruptured Abdominal Aortic Aneurysm Examiner Sequentially list conditions, if any, laeding to immediata causa. Enter Underlying Causa (Disaase or Injury that initiated events resulting in death) Last attending physician end for use as the burlel-tran Dua to (or as a consequence of) 68760 Physician/Medical Dua to (or as e consequence of) Box (Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? O signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, ð 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1□ Yes 20 No 1 Yes 20 No certificata Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifice. director, Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospital: 1 12 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Mannet of Death 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28a. Place of fnjury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) in by 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. Medicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) Lillie MA D53244 November 13, 1999 30. Neme end addrass of person who completed cause of death (frem 23a) (Type, Print) Katharine R. Lillie, MD 11140 Rockville Pike #348, Rockville, MD 20852

Registrar

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31. Data filed (Mgrth, Day, Year) NOV 15

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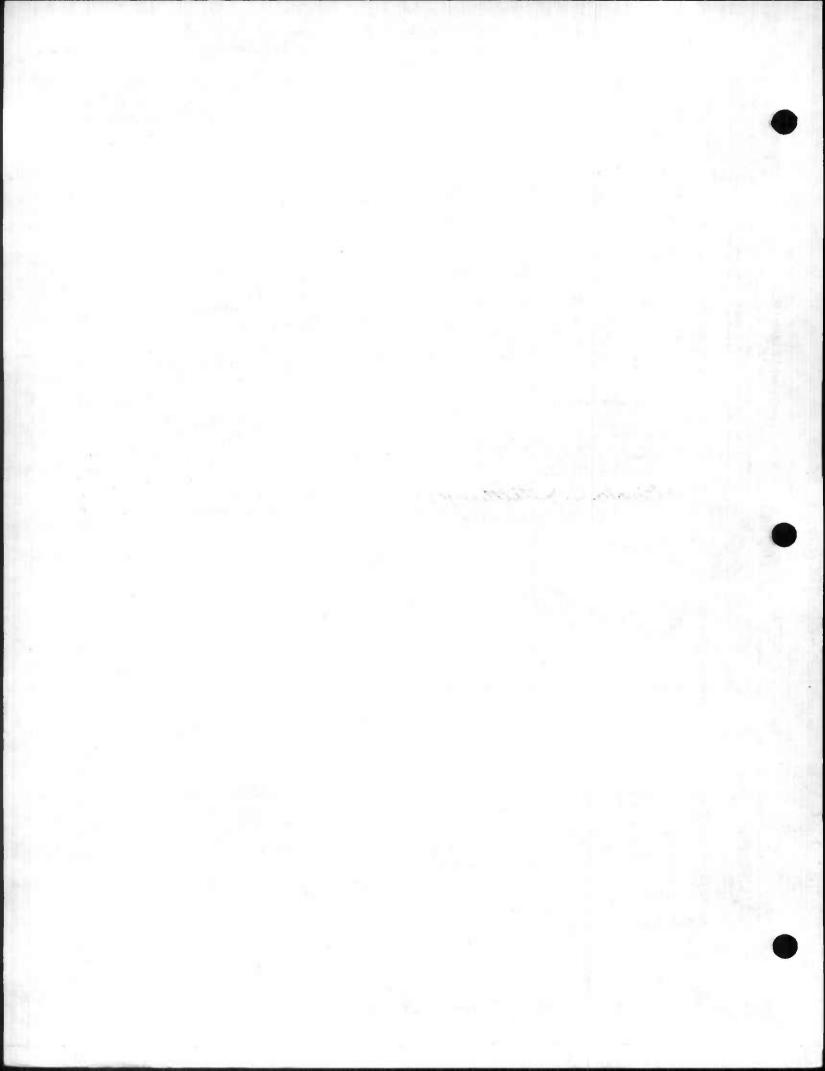
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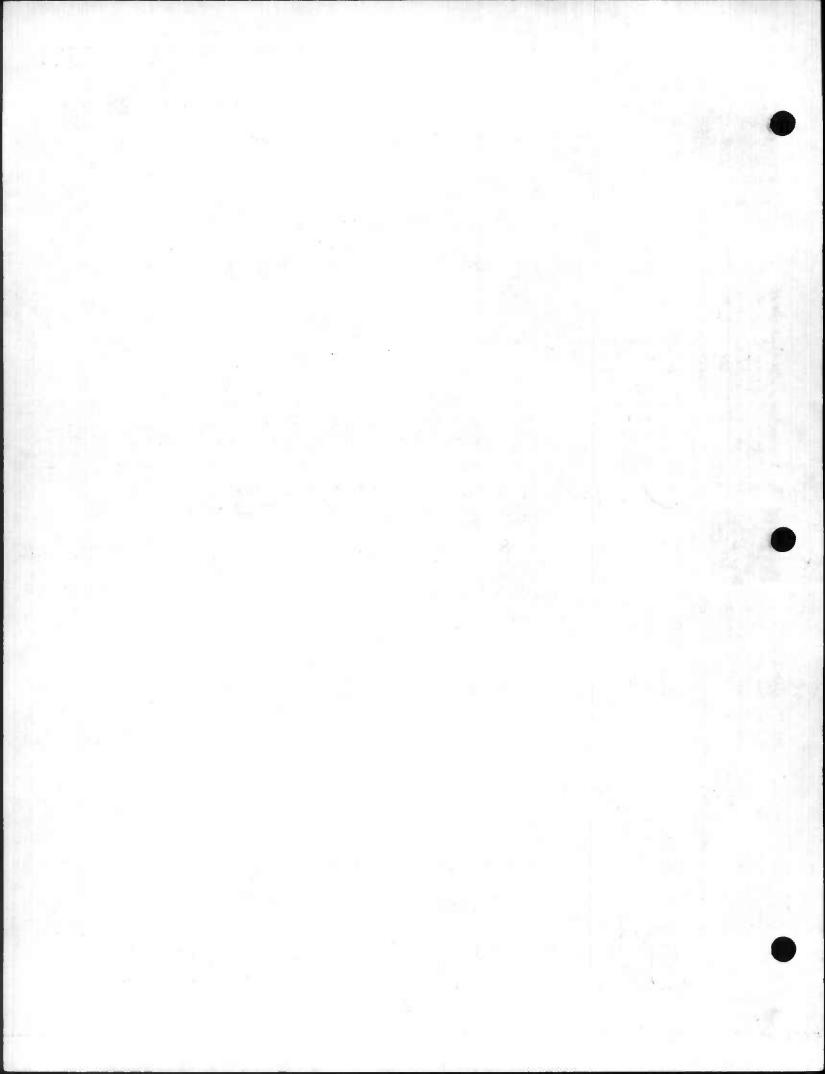
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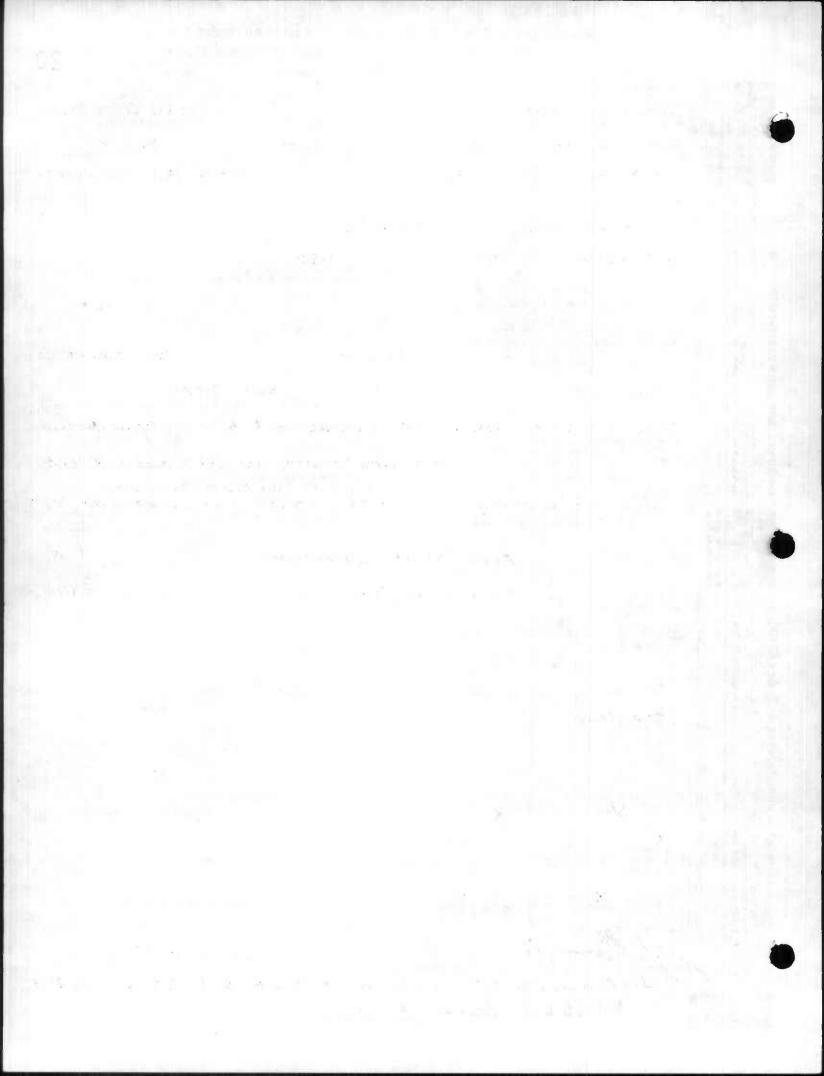
State of Maryland / Department of Health and Mental Hygiene 00 27527

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/Medical	4a Facility Name (If not institution, gi	ve street and number)			4b. City. To	wn, or Location of Do	- 0 9 - eeth 4c. County o	7) / 1 200	
Examiner	Levin Dale H		iatric	Cent	-	timore		imore County	
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를 일표 🗅	10e. Street and Number 611 Edgewood	Street			Zip Code 20018		10g. Citizen of WI USA	net Country?	
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State of Maryland / Department of Health and Mental Hygiene 9 9 375

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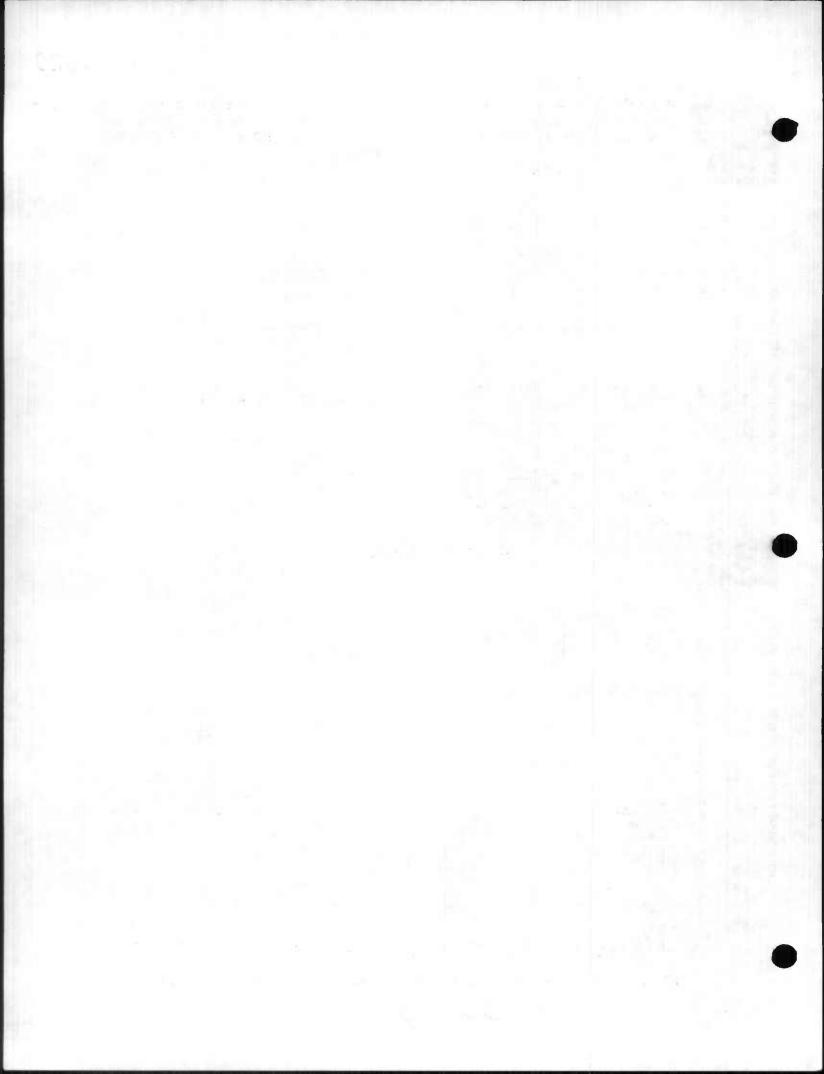


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death NOVEMBER 10, 1999 **Physician** ROBERT STEVEN STROUD JR. 2:45AM /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 314 WOODSIDE PLACE WALDORF CHARLES If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (in vrs. last birthday) 8. Data of Birth (Month, Day, Year) April 27, 9. Birthplace (Stata or Foraign Country)
Virginia **Funeral** XXXM 2DF Months Days Hours Min. 222-22-9761 61 1938 Director Usual Rasidence of Decedant with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Charles Waldorf 1 ☐ Yas XIX No MD Directo 10e. Street and Number 10f. Zio Coda 10g. Citizen of What Country? 314 Woodside Place 20601 IISA death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1XDXYas 2 □ No 1 9 5 5 If Yes, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. 11. Maritai Status Black, Whita, atc. ss 1 and 2 should be filed within 72 hours after of Health end Mental Hygiene. Item 27 is marked other than "natural", or Ite 1 Nevar Married XX Married altimore, Maryland 21215-0020 1 Yas 2X No Specify: à 3 ☐ Widowad 4 ☐ Divorced White Yaar or Datas: 1959 Completed 16b. Kind of Businass/Industry 15. Decadant's Education 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) Furniture - Retail Salesman 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Robert Steven Stroud, Sr. Katherine Elizabeth Butler 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Leora Layne Stroud - Spouse 314 Woodside Place Waldorf, Maryland 20601 other 1 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Peges nent of H ant: If ite XXBurial , 2 Cramation 3 Ramoval from Stata permit. Pege Department of Important: If any injury or once. Parksley Cemetery 11/13/99 Parksley, VA 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility ol Funaral Sarvice Licansaa Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310 ther the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, the heart failure. List only one cause on each line. Approximata Interval Betwaen Onsat and Daath **Physician** /Medical Immediata Causa (Final PROSTATE CANCER disaasa or condition resulting in deeth) Examiner Due to (or es a consaquance of): Examiner requires that the death certificate be executed burial-transit pue Sequentielly list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): physician s the burial Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): 88 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performad? peen complation of causa of death? page 2 s 1 ☐ Yas 2XXNo 1 Yas certificate 2000 Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified director. 25. Was casa ratarrad to medical Be 28. Placa of Death (Check only ona) 1 Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5XX asidence 8 Other (Specify) 2 funeral 27. Mennar of Death 1 Natural 28e. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Pending Injury 1 ☐ Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 2 4 \ Homicida 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. edical 29a, Cartifian To the Hosp within 24 hor To the Fune completely fi | Certifying Physician: 10 this best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar stated. (Check only one) 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) D28352 NOVEMBER 10, 1999 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) KRISHAN MATHUR, MD., P.O. BOX 1703, LA PLATA, MD

State Registrar 31. Date filed (Month, Day, Year) NOV 15 1999

32. Registrar's Signatura

B. Sparks

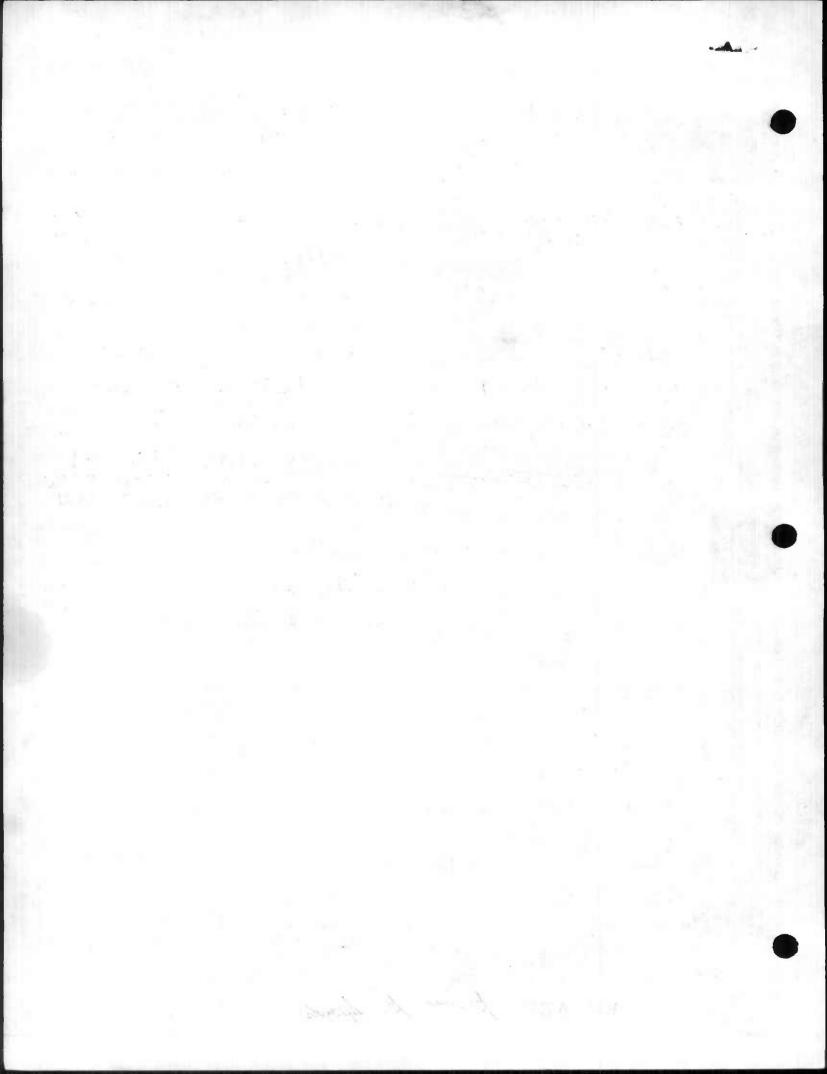


Registrar

State

32. Registrar's Signature

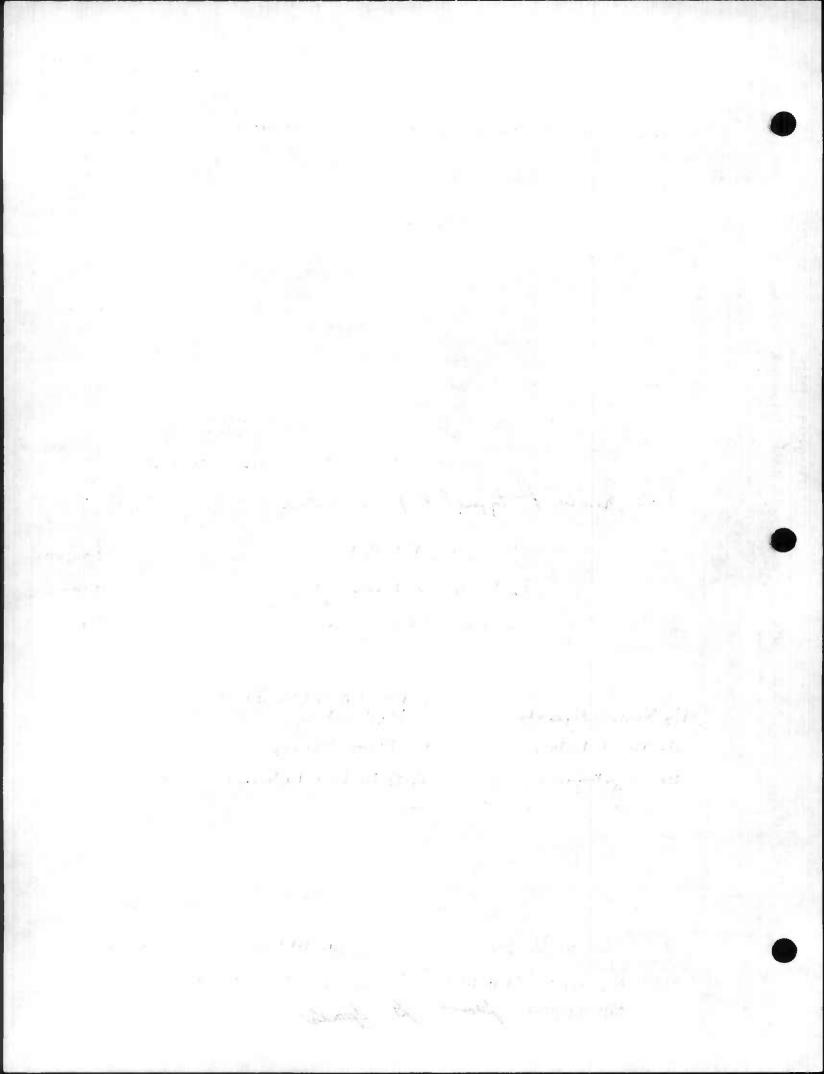
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of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	99	2752	1
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or Attending Physicien: The law requires that the deeth cent acted deeth. Director: After this centificate has been signed by the attending in by the funeral director, page 2 should be detached for use ertification: To Be Completed by Physician/M	1) 0		0	. 51	24a. Was	an autopsy 2	4b. Were eutopsy findir
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ng Ph therth meral	27. Menner of Death Neturel 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of tnjury	28c. Injury at Work?	28d. Describe	how injury occurred	
the fu	2 Accident Investigation 3 Suicide 6 Could not be		N.	1 Yes 2 No			
or Att	4 Homicide determined	28e. Plece of Injury - A building, etc. (Sp.	t home, farm, street, f ecify)	actory, office	28f. Location (City or To	Street and Number (wn, State)	or Rurat Route Number,
To the Hospital or Attending Physicien: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Certifying Ph	veiclen: To the best of my	knowladae deeth one	urred at the time, date end pl	and due to the	severale) and man	or an etated
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4 5 4 5 P	29b. Signeture end title of certifier			29c. License number		29d. Date signed (/	Month, Dey, Year)
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To To To N	30. Neme and ad top of person who	completed cause of death (Item 23a) (Type, Print			11.7-	4
or o	30. Neme and address of person who to the total of the to						М

DHMH 16 Rev 6/95



DHMH 16 Rsv 6/95

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	Physic /Medi		1. Decedent's Neme (First, Middle ADDIE TALLEY								2. Date of De	Qà	ğg		ime of Death
۹	Exami	ner	4a. Fecility Nama (If not institution LARKIN CHASE		CT-1			100	b. City, To	100	ocation of Deat	4c. Count		EOI	RGE'S
	Funeral Director		5. Social Security Number 237–54–6767	6. Sex 1 □ M 2 🔏 F	7. Age (In yrs. I	ast birthdey) Yrs.	If Under Months	Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da October	7, Year	9. Birthr Cour Vir	plece (S ntry) gin:	State or Foreign
	the Maryland 28a-f show notified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number	George's		Town or Lo								130	ide City Llmits
	N with	al Dir	11813 Frost Dri	ve			10f. Zip (0720			10g. Citizen of U.S.		ntry ?	
020	within 72 hours effer death with the Maryland ene, than "naturel", or liems 23e or 28a-f show he Moulcal Examiner must be notified at	by Funeral Director	11. Maritel Status 1 Never Merried 2 Marri 3 Widowed 4 Divorced	12. Was Deced Armed Ford ed 1 Yes 2 If Yes, Give Yeer or Dat	ces? 2 💢 No		Wes Deceder of Yes, speci		ispanic On en, Mexicar Specify:		pecify Yes or No o Rican, etc.)	14. Ra Bla Specia	ca - Americack, White,		
21215-0020	filed within 72 ho Hygiene. rther than "natur ent, the Moucal	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 8th		4or 5+)	16a. Deced (Give life.	dent's Usuel kind of work DO NOT use House	done de retired	during mos ()	t of wor	king	16b. Kind of E	ivate	dustry	
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Baltimore, Mai	80 = 5		19a. Informant's Name/Relations! Carolyn Alexand 20a. Method of Disposition 1 □ Burial 2 □ Cremation	er/Daughte	20b. Pl		Frost sition (Nem	of her place	ive,	Bow	ie, Mar	yland 2 20c. Location	0720 - City or To	own, Sta	ate
Baltir	permit. Per Depertment Important: eny Injury once.		4 Donetion 5 Other (Sp. 21. Signature of Funeral Servica I		+:	J^{22}	B. JE	Addre NKI	ss of Facilit	NER	1999 AL HOME , Landov	Boydton			
68760,	Physician per	edical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of the shock	a. RE	Due to (or	es e consequence as a c	juenca of):	of dyln			UR			Interv	ximate all Between and Deeth
rds, P.O. Box	ss that the death gned by the etter be detached for to	d by Physician/M	Part II. Other algnificent condition	d	oth put not resu	Iting In the u	nderlying ca	use giv	en in Part I	l.	10	tobacco use co Yes 2□ No an eutopsy	3☐ Proi	bebly ere auto	4 Unknow
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/ital	iclen: The certificate rector, pag	Be	25. Wes case referred to medical examiner?	Hospital:							th (Check only o	one)			
Division of	y sign	27. Menner of Death 1 Seteurel 5 Panding 29. Accident Investigation 3 Suicide 6 Could not be							/ et		Home 5 ☐ Residenca 8 ☐ Other (Specify) 28d. Describe how Injury occurred				
Divi	To the Hospital or Attending Pi within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funera		4 Homicide determine the determine d	ned 289. Pieca o building	of Injury - At hor g, etc. (Specify, est of my know	ledge, death	occurred e	t the tim	ne, date an	d place	City or To	cause(s) and m	anner as s	tated	
	To the Ho within 24: To the Fu	Medical	(Check only one) 2 Medical E 29b. Signature and title of certifier	caminer: On the bas and manne	ils of examineti	on and/or Inv	astigation, I	n my o	number	th occur	rred at the time,	29d. Date sign	and due to	o the ca	
_	(6)		30. Name and address of person v	tho completed cause $0-4000$	of death (Item	23e) (Type (Tint)	61	Road	件:	220.	Powie,	MD	-2	10716
	Sta Registr	-	31. Dete filed (Month, Day, Year)		gistrar's Signati	<u>4</u>	lan	400			-1-	-			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Con Da

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death NOV. 6, 1995 **Physician** William Bain Thompson 1:05 PM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) Examiner 2503 Kitmore Lane Bowie Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□ F 74 Yrs. 363-20-9395 Director July 28,1925 Louisiana Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f ahow 1 Yes 2 □ No Directo Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 "natural", or items 23s 2503 Kitmore Lane 20715 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ■ Never Merried 2 ■ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Security scanner U.S. Gov't permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other trauments 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Silas Lavell Thompson Ada Russell 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Carroll Thompson - wife 2503 Kitmore Ln., Bowie, Md. 20715 11-Date - 9920c. Location - City or Town, State 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Buriel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) Md. Veterans Cemetery Crownsville, Md. 21. Signeture of Funeral Service License 22. Name end Address of Facility Robert G. Beall M00025 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death **Physician** LUNG CANCER

Due to (or as e consequence of): Immediete Cause (Finel diseese or condition resulting In death) /Medical Year Examiner Examiner that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Last Due to (or es a consequence of) P.O. Box 68760. Physician/Medical Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed to Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No certificata Division of Vital as or Attending Physician: To safter death.

In Director: After this certificat ed in by the funaral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menger of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident Investigetion 6 ☐ Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide thin 24 hours aftar de the Funeral Directo 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. To the Foundation 2 29b. Signature and title of certifier 29c. License number MD21359 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Naiyer A. Rizvi, MD., 3800 Reservoir Rd., N.W., Wash. D.C. 20007-2223 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State NOV 0 9 1999 Registrar

Administration of the last

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State of Maryland / Department of Health and Mental Hygiene 99 37534

						Cei	rtifica	te of	Death		R	eg. No.) 0	100	
	Dhualaian	1. Decedent's Name (Fi	rst, Middle, Las)							Dete of Dea Month	th _ Day	Year	3. Time of Dea	ath
	Physician /Medical	WILLIAM PURCELL TAYLOR									ovember			6:00 A.M	
	Examiner	4a Facility Name (If not institution, give street and number)											4c. County of Death		
		9013 Mill Street Fort Washington Prince George													
	Funeral Director	220-26-6896 X M 20 F				ge (In yrs. last birthday) ff Under 1 Year If Under 24 Months Deys Hours If Under 24 Months Months Deys Hours If Under 24 Months Mont			Min. 8. I	Date of Birth Month, Day UGUST 9	e of Birth nth, Day, Year) ust 9, 1931 9. Birthplace (State or Foreign Country) Maryland			reign	
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	sho sho									1 ☑ Yes 2					
	with the Me or 28e-fe		10e. Street and Number			ge's Fort Washington			Code			10g. Citizen of What Country?			
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21215-0020	2 should be illed within 72 hours effer deeth with the Meryland is and Mental Hyglane. Is marked other than "natural", or hame 23a or 28a-f show reumatic event, the Medical Examination must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 ☐ No If Yes, Give Year or Detes:		1	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuben, Mexican, Puerto Ri □ Yes 2 ♥ No Specify:							White, etc.	
5-0	ed within 72 ho yglene. r, er then "neturn ft, fr.		Decedent's Edu			(Give	Decedent's Usual Occupation (Give kind of work done during most of work)			f working		16b. Kind of B	16b. Kind of Business/Indu		
21	de de		Elementary/Secondary (0-12) College (1-4or				5+) life. DO NOT use			use retired)					
2	Co. Harde	12th Grade				Repea	ter C	hief				United:		Army	
E	De dott	17. Father's Name (First					18. Mother's Neme (First,					Middle, Maiden Sumame)			
YB	Men Men To	William M.								e Greei					
, Maryland	and 2 sh saith and s 27 le m or treum	Mrs. Annie E		ype, Print)		100000000000000000000000000000000000000	_	11 - 2				r. City or Town, lary land		lode)	
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other treumatic event, tha Magas. To Be Compl	20a. Method of Dispositi 1 Durial 2 Cr 4 Donation 5 D	emetion 3 DF		le C	Place of Dispo cemetery, crem ~vland V	natory or	other ple			10.00	20c. Location - Cheltenh			
Balti	permit. Page Department Important: If any injury or pages.	21. Signature of Funeral Service Licensee 22. Name						an's Cemetery 11-09-99 Cheltenham, Maryland and Address of Facility Rollins Funeral Home, Inc. unt Place, N.E. Washington, D.C. 20019					<i>y</i> ,		
		23a. Parti. Enler the di	10	male	Les	4								Approximate	
	/Medical Examiner Lieuted Lieuted Examiner Examiner	Immediate Cause (Fina disease or condition resulting in death)		Due to (or as a consequence of):								2/98diag	nose		
68760,			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			C. Due to (or as a consequence of):									
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	deeth ce etendir ed for use sician/	Part II. Other significant	Part II. Other significant conditions contributing to death but not resulting					ng in the underlying cause given in Pert I.				obacco use co	intribute to 1	the cause of d	eath?
P.0											101	es 2 No	3 Probe	ably ধ Uni	unown
Records,	aw requi						_	24a. Wes a perfor	n autopsy med?	com	re autopsy findi lable prior to apletion of caus eath?	-			
II Rec	The lew ate has b page 2 e									1 🗆 Y	es 2 No	10	Yes 2 No		
	centificate rector, per	25. Was case referred to	o medical	26. Place of Death (Check only one)											
>		examiner? 1 ☐ Yes 2 ☒ No		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific						ner (Specify)					
on of	for for	27. Manner of Death 1 2 Natural 5	Pending investigation	28a. Date of Ir (Month, L	jury Day Year)	28b. Time of Injury	М	28c. Inju Wo 1	nyat nk?]Yes 2∐No		Describe h	ow injury occur	rred		
Division	2495	3 Suicide 6 Could not b determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f.	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Hospi 14 hour Funer tely fill											ted. the cause(s)			
	within 2 To the comple	29b. Signature end title	A CONTRACT OF THE CONTRACT OF						29c. License number			29d. Dete signed (Month, Day, Year)			
	(Jean Gen				MD25275					November 4, 1999				
	(10)	30. Name and address of person who completed cause of death (Item 23n) (Type, Print) Jean Grem, M.D. NNMC Building 8 Room 5101 Bethesda, MD 20889													
	State Registrar	31. Date filed (Month, Di		32. Regis	strar's Signa	lure	1	-							

from a day

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State of Maryland / Department of Health and Mental Hygiene

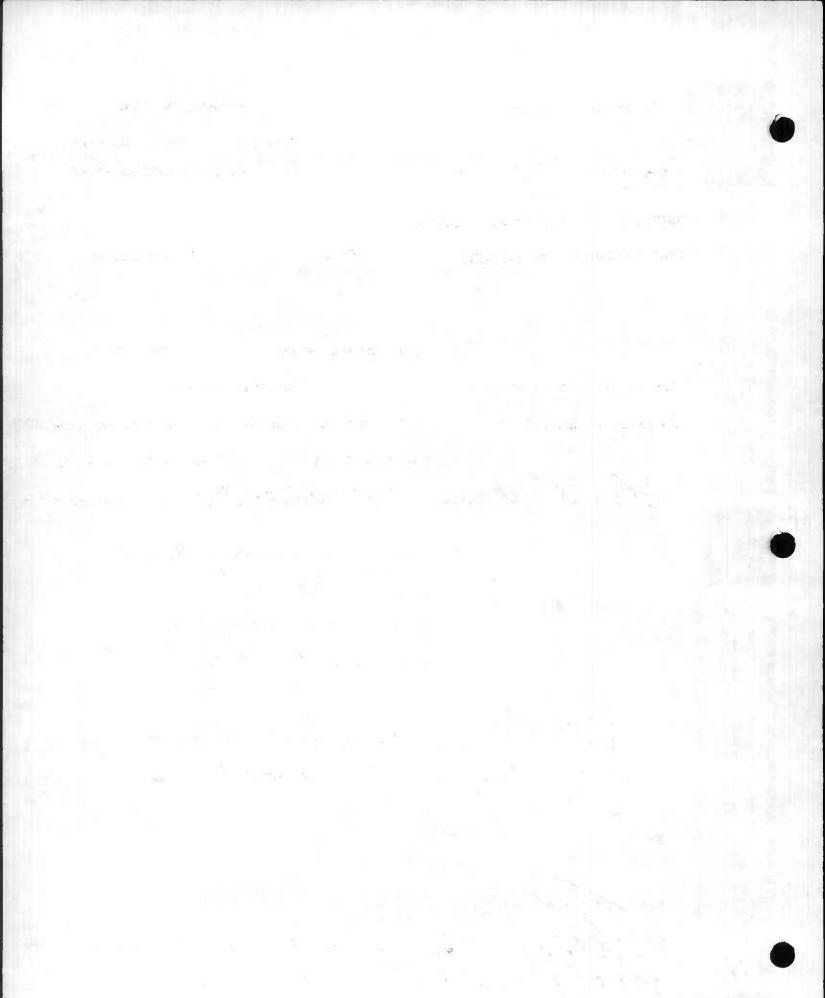
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	Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey Yeer 3. Time of Deeph								
Physician /Medical	Glenn Allen Trageser			, 1999 1:05 AM							
Examiner	4e Fecility Neme (If not institution, give street end number)		. County of Death								
Examino	Prince Georges Hospital Center	Cheve	rly Pri	ince Georges							
neral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday)	Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Fore							
ector	216-60-4570 1M 2DF 46 Yrs. M	onths Deys Hours Min.	March 25.1	953 Maryland							
	Usuel Residence of Decedent			JJJ Harly Land							
rector	10e. Stete 10b. County 10c. City, Town or Locati	on		10d. Inside City Lim							
o	Maryland Prince Georges Laurel			1 ☐ Yes 2 ¹ ⁄⁄ ₂							
Directo	8-1	Of, Zip Code	10g. Citizen of What Country?								
	8803 Hawthorne Lane (apt.T2)	20708	8 United States								
Funeral				14. Raca - American Indien,							
5	Armed Forces? If Ye 1 Never Married 2 Married 1 Yes 2 No	Decedent of Hispenic Origin? (S s, specify Cuben, Mexican, Puer	rto Rican, etc.)	Bleck, White, etc.							
by F	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	Yes 2⊠ No Specify:		Specify: White							
		la Maural Oncumention	1 1ch H	Sind of Business/Industry							
Completed	15. Decedent's Education (Specify only highest grade completed)	's Usuel Occupation d of work done during most of wo NOT use retired)	orking 160. K	and or business/industry							
d E		ounterperson		utomotive							
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Be				st, Middle, Maiden Sumeme)							
2	Herbert William Trageser		ret Ann Farr								
		ddress (Street end Number or Ri	•								
	Jo Ellen Rhodes/Friend 8803 H	awthorne Lane,	(apt.T2), La	urel, Maryland 20							
	20e. Method of Disposition 1 Buriei 2 Coremetion 3 Removel from State	in (Neme of ory or other place)	Dete 20c. L	ocation - City or Town, State							
	4 Donetion 5 Other (Specify) Fort Lincol	ln Crematory	11-07-99 Bre	entwood, Maryland							
ei .	21. Signafure of Engeral Service Lipensee 22. Name end Address of Fecility										
8000											
	Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland										
-	23a. Part1. Enter the disease, or completions that caused the death. Do not enter t shock, or heart failure. List only one cause on each line.	ie mode or dying, such es cardia	ic or respiretory errest,	Approximete Intervel Between Onset end Deet							
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edicai	that initiated events resulting in death) Lest	ce of):	2	2							
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M/ue	d. Oronary 19 1 ft.										
icle	Pert li. Other eignificant conditions contributing to death but not resulting in the under	riving cause given in Pert I.	23b. Did tobacco	use contribute to the cause of de							
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ete	I The II Viasetes 100	ritu	performed?	eveileble prior to completion of cause							
Completed	Second of deeth?										
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atio	1 DNaturel 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No									
=	3 ☐ Suicide 6 ☐ Could not be 28e. Plece of Injury - At home, ferm, street	fectory, office	281. Location (Street and Number or Rurel Route Number,								
P	4 Homicide building, etc. (Specify)										
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edicai Certification:	(Check on Pical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s)										
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	16 Klimb C. Louis	- 1292	0) //0	Vember 5, 19							
	30 Name and address of person who completed ceuse of death (Item 23a) (Type, Prin	it)		Center 5, 19							
	FEZIPE CI ROBINSON	VC-N	VANIA	(enter							

G. Sports

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State

Registrar



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician REGINA omp son JAMES 2:23 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 8. Date of Birth (Month, Day, Year) SEPT. 4, 1940 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Birthplace (State or Foreign Country)
 VIRGINIA 6 Sax 7. Age (In yrs. lest birthday) **Funeral** Days XXX 2 F 59 Yrs. 577-54-4307 Director Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits tion 27 is marked other than "natural", or itema 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at SILVER SPRING 1 Yes 2 □ No Director MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 UNITED STATES 3841 TYNEWICK DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give "natural", or [Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) N/A UNEMPLOYED 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental Himportant: if Item 27 Ia marked oth any Injury or other traumatic even Be JAMES HENRY ALTHEA COLEMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1610 Golf Course Dr. Mitchellville, MD 20721 19a. Informant's Name/Relationship (Type, Print) KEITH THOMPSON / SON 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete GLENWOOD CEMETERY WASHINGTON D.C. NOV. 10, 1999 22. Name and Address of Facility Dudley Funeral Home 21. Signature of Funaral Service Licensee Dudley E_{M} RHODE ISLAND AVENUE, MT. RAINIER MD 23a/Part1. Enter the disease, or complications that caused the death. For not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Final disaasa or condition resulting in death) /Medical yeurs Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 signed by the 2 No 3 Probably 4 Unknown Records, by cate has been significant category. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 2 110 1 ☐ Yes 1 ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartification pletaly filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient 2 ER/Outpatient 3 DOA To 1 Yes 2 No Certification: 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homleide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation in my existing death occurred at the time, date and place, and due to the cause(s) end manner es stated. 29a. Certifier Medical Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year) NOV nd address of person who completed cause of death (Item 23a) (Type, Print) RONAH BOCCIA MD 707 median Center Qu 31. Date filed (Month, Dey, Year) NUV 0 8 1999 32 Registrar's Signature State Registrar

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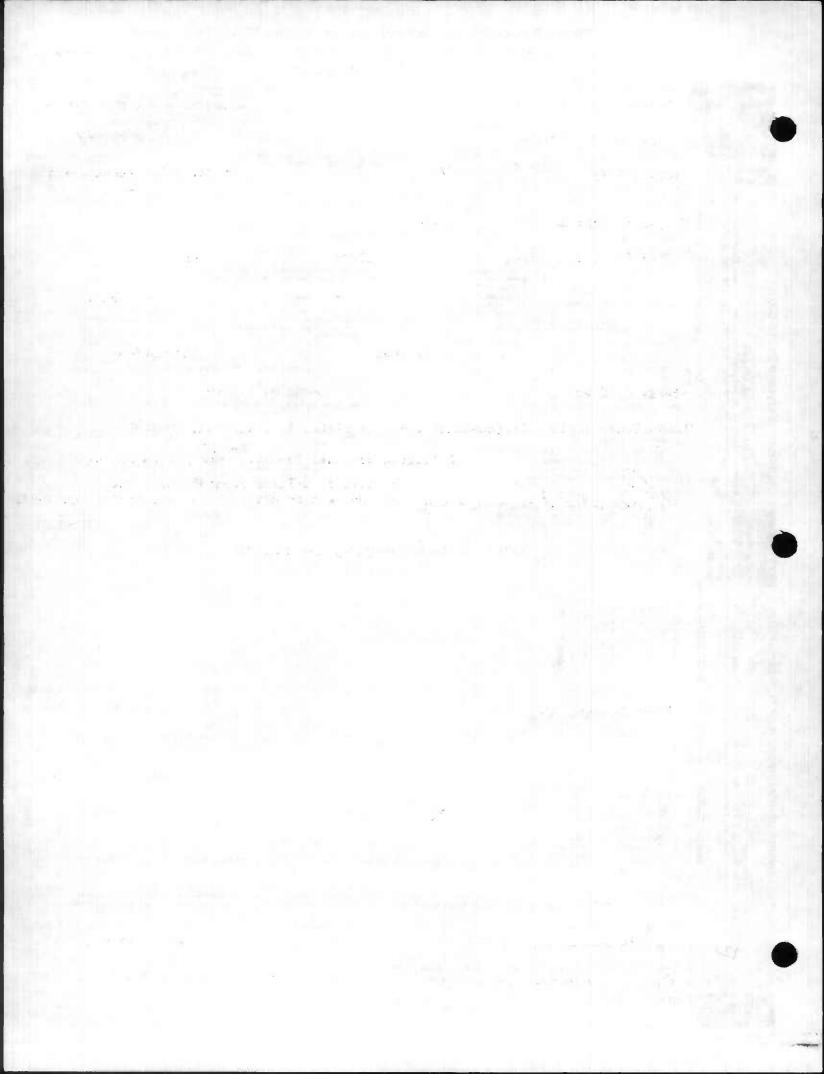
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Physician Function Fu		1. Decedent's Name (First, Mide	dle, Last)		301	tificate of		2. Date of De		3. Time of [
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State of Maryland / Department of Health and Mental Hygiene

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Examin		4e Facility Neme (If not institution, g	give street and number)				4b. City, Town, or SILUGIL SP			of Death	607
Funeral Director		5. Social Security Number 6 180-14-6737 Usual Residence of Dacedant	. Sex 7. A	ge (In yrs. 77	last birthday) Yrs.	If Unda Months	Deys	If Under 24 Hrs Hours Min.		v. Year)		eca (State or Foreign try) Sylvania
yland		10e. Stete 10b. County		10c. Ci	ty, Town or Lo	ocation					10	Od. Inside City Limits
a Mar	ctor	Maryland Montgon	nery	Whe	aton							1 ☐ Yes 2 No
th with th	al Directo	10e. Street and Number 12601 Littleton	Street			10f. Zij	Code		ı	10g. Citizan of 1	Whet Coun	try?
Maryidand 21213-0020 Ind 2 should be filed within 72 hours efter death with the Maryland Ind and Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examere must be notified.	by Funeral	11. Maritel Status 1 Never Married 2 Member 3 Widowed 4 Divorced	12. Was Deceden Armed Forcas 1	? (No		Was Dece if Yas, spe 1 ☐ Yes		Hispenic Origin? (S an, Mexican, Puar Specify:	Specify Yas or No to Rican, atc.)		ce - Americ ck, Whita, ov Whita	etc.
72 hours	Completed	15. Decedent's (Specify only highest of			16a. Dece (Give	dent's Usu kind of we	ai Occup	petion during most of wo d)	rking	16b. Kind of B	usiness/Inc	lustry
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iryian should be nd Mental markad c	To Be	George J. Sabol						Anna M.	Cearto			
Maryla d 2 should th and Men 7 is marka traumatic		19e. Informant's Name/Ralationship	(Type, Print)		19b. Meili	ing Addres	s (Stree	and Number or R		er, City or Town	Stata, Zip	Code)
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permit. Paga: Department of Important: If i any injury or once.		4 □ Donetion 5 □ Other (Special Signature of Funeral Service Lice	**	AI						Arlingt	the land to the la	/A
Demi Depa Impo		23a. Pert1. Enter the diseese, or co shock, or heart failure. List on	emplications that cause	ed the dea	1 5	00 Un	ive		d., W, S	Silver S		g, MD 2090 Approximata Interval Batween
Physician /Medical Examiner		Immediata Causa (Final disaasa or condition resulting in death)		1 1	oric C	Mojou	MBCC	our diser	755		1	Onsat and Daath
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al di	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpat		ER/Outpatie		UA		Home 5 Resi			y)
Ing Wittar	tlon	1. Natural 5 ☐ Pending	28e. Dete of In (Month, D	ay Year)	28b. Time of Injury	M	28c. Inju Wo	ork? Yes 2 No	200. Dascribe	8d. Dascribe how injury occurred		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Amend #1, 11/17/99, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician Month Dev Mary Titus Jane November 10, 8:15PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Spa Creek Annapolis Anne Arundel 8. Dete of Birth (Month, Day, Year) 14 If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months 10 M 20 F Virginia 85 Yrs. 578-12-0970 Director Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits worle r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Anne Arundel Director Maryland Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 U.S.A. 1389 Bayside Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Bleck, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: specity: White p 3 ₩ Widowed 4 Divorced Complated 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Medical Office Receptionist 12 permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygies Important: If Item 27 is marked other tt any Injury or other traumatic avant, Its ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 8 Ethel Hough Charles Manley Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1389 Bayside Dr. Edgewater, MD 21037 Jane L. Burroughs/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/99 Leesburg, VA Union Cemetery 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service License 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 683 12 Ridgely Avenue, Annapolis, MD 21401 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete tntervel Between Onset and Death 23a, Part1. Enter the disc shock, or heart failu Physician tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence Examinar ettending physician and i for use as the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es s consequence of): Box 68760 Physician/Medicai Due to (or es e consequence of) P.O. signed by the e Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 No cartificata of Vital Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this cartificately filled in by the funeral director, 88 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 (Wetural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di complately filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier

State Registrar

B

29b. Signature and title of contribut

Sinp

Day. Year)

MD

1999 7

person who completed cause of death (Item 23s) (Type, Print)

32. Registrar's Signeture

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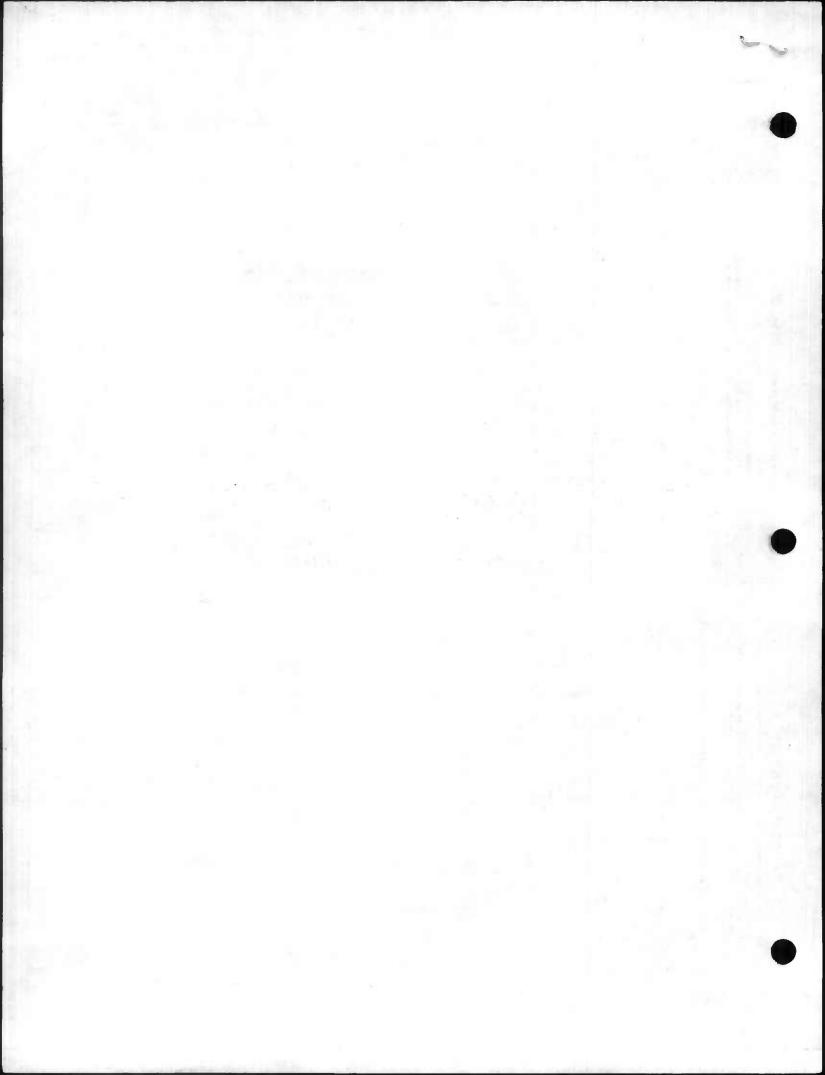
29c. License number

389

how

29d. Date signed (Month, Dey, Year)

Road #106 oderston MD 21113



State of Maryland / Department of Health and Mental Hygiene 99 37540

		Certificate	of Death	Reg	ı. No.	0 / 1	540
	Decedent's Neme (First, Middle, Last)			2. Date of Death			ime of Death
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/Medica	do Facility blame (Mant Institution aire street and symbol)		4b. City, Town, or L		4c. County of		30
Examine		44-1					
	Fallston General Hosp		Falls1		Harfo		24- A F
Funeral Director	5. Social Security Number 6. Sex 100 1 7. Age (In year) 7. Age (In year) 100 2 F 75	Months	Days Hours Min.	8. Dete of Birth (Month, Day, Y) 1/07/19		9. Birthplace (S Country) ennsyl	
puel *		City, Town or Location				10d. Ins	ide City Limits
he Mery	md Harford 10e. Street and Number	Pylesville		100	011		Yes 2 Typ
23a or 2	10e. Street and Number 715 Old St. Mary's Rd	l •	21132	109	USA	net Country?	
urs e	11. Marital Status 1 Never Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in Armed Forces? 1 Yes 3 No If Yes, Give Year or Dates:	U,S. 13. Was Decede If Yes, specif	nt of Hispenic Origin? (Spy Cuban, Mexican, Puerto	pecify Yes or No- p Rican, efc.)	Bleck	- American Indi , White, etc. White	an,
Z1Z15-UUZU d within 72 hours of jiene. then "netural", or the Mod cal Exert	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual (Give kind of work life. DO NOT use	done during most of work	king	b. Kind of Bus		
Iryland 212 should be filed within at Mentel Hygiene. Immits event, the M	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 17. Father's Name (First, Middle, Last)	Zoning Ad	ministrato			Govern	ment
S S S S S	L. Graham Thompson			n Kilgor			
Maryla d 2 should th end Men T is marks traumatic	19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Ru	rel Route Number, C	City or Town, S	itete, Zip Code)	
	gloria R. Thompson- wife	715 01d S	t. Mary's	Rd., Py1	esvil:	le,MD	21132
E - 1 2 2	1 M Norial 2 ☐ Cremation 3 ☐ Removal from State	Placa of Disposition (Name cemetery, crematory or oth	er place)			City or Town, Sta	ate
It In	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Logscee	ate Ridge		11/1//99	Delt	a,PA	
permit. Pages Depertment of important: If i any injury or once.	Helley P. Tweles	//	Address of Fecility S F.H.Inc	,600 Ma	in St		314 a,PA
Oharaining	23/. Part. Effer the disease, or complications that caused the de nock, or heart failure. List only one cause on each line.	at ODo not enter the mode	of dying, such es cardiac	or respiretory arres	t,	Interv	el Between t and Death
Physician /Medical	Immediate Cause (Final	(17)	1 440 0110	in A		14	112016
Examiner	disease or condition resulting in death)	. Cen	LympHo	W 7		0	L1119
		(or as a consequence of):	*				
outed nd ransit	Sequentially list conditions Due to	(or as a consequence of):				i	
BOX 66/60, eath certificete be executed attending physician and for use as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lesf	(or as a consequence of):					
that the death certined by the attending deteched for use a	d.		and the state of t	22h Did toh		tribute to the ca	auga of death?
of the d by the establishment	Part II. Other eignificant conditions contributing to death but not re	esulting in the underlying call	ise given in Part I.		1		4 ☐ Unknowr
0 8 60 1				1 🗆 Yee	2.€ No	3 Probably	4 Onknown
requii				24a. Was en performe		24b. Were aut available completio of death?	prior to on of cause
E 9 4 55				1 ☐ Yes	2 No	1 🗆 Yes	2 No
VICIAN: TI			26. Place of Dea	th (Check only one)			
hysicii his cer il direc		☐ ER/Outpatient 3☐ DOA	Other:	ome 5 Residen		r (Specify)	
) f f .			c. Injury at Work?	. 28d. Describe how			
To the Mospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Placa of Injury - At building, etc. (Spec	home, farm, street, factory, cify)		28f. Location (Stre City or Town,		r or Rural Route	e Number,
he Hospita in 24 hours he Funera pletely fille		nowledge, deeth occurred at nation end/or investigation, I	the time, dete end place n my opinion, deeth occu	, and due to the cau rred et the time, date	se(s) and man e and place, ar	ner as stated. nd due to the ca	ause(s)
o the o the omple	29b. Signature and title of confiner	290	Elcense number	290	d. Date signed	(Month, Day, Y	'ear)
F > F 8	LI GALIAN	1700					
16	71 00000		31775	1	1/13/	TDAA	
LS	30. Name and address of person who completed cause of death (fig	em 23a) (Type, Print)					
	Joan P. Edwards, MD, 211		Rd., Fall:	ston, MD	21047		
State	4.0	nature	,				
Registra	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	- 19					

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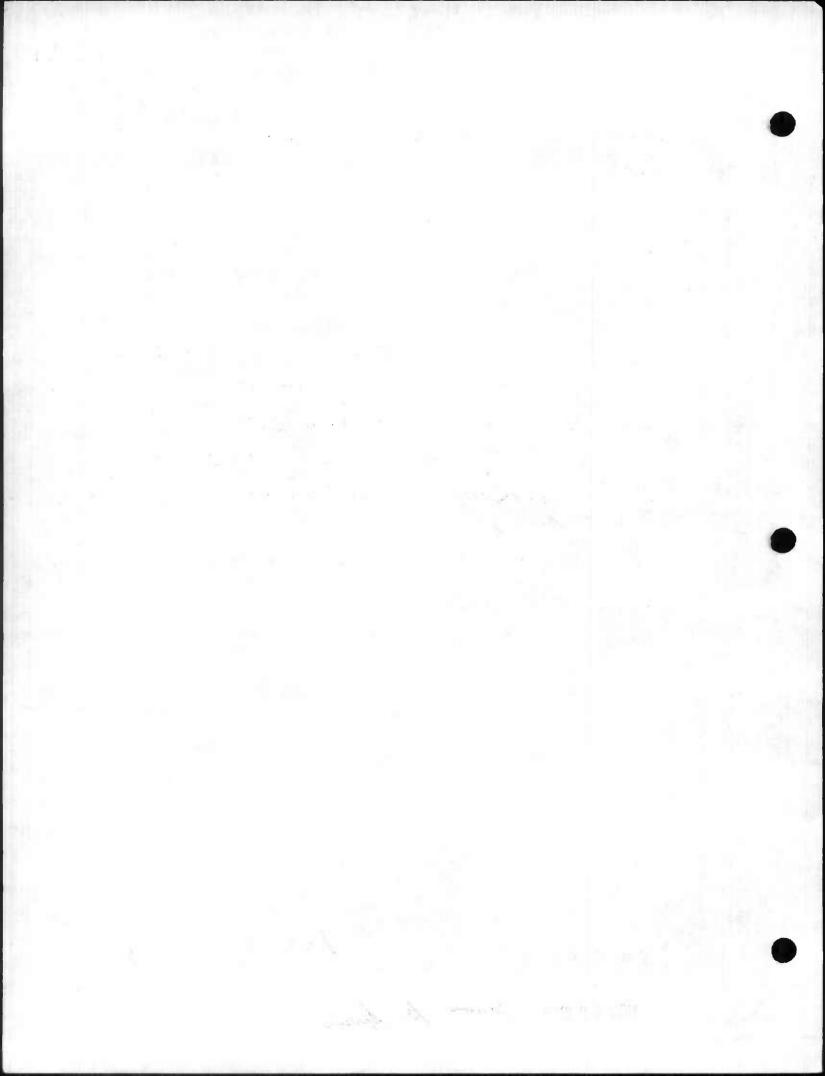
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show show	10a. State	10b. County	214		ty, Town or Loc	ation					e City Limits
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atter death or thems 23s miles must	11. Maritel Stetus		12. Was Dece Armed Fo	2 No			Hispanic Origin? (ban, Maxican, Pue	Specify Yes or N rto Rican, etc.)	o- 14. Rac Bla	ce - American Indian ck, Whita, etc. v: WHITE	l _e
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ysic ysic	Pert II. Other sign	nificant conditions	contributing to de	eath but not res	sulting In the un	derlying cause g	given in Part I.	23b. Did	tobacco use co	intribute to the cau	se of death?
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, par Medical Certification: To Be Co	27. Mannar of De 1 Naturat 2 Accident	5 Panding	28a, Data (Mont	of Injury th, Day Year)	28b. Time of Injury	28c. Inj		1	how injury occur		
DIVISION (Lai or Attending P rs after death. al Director: After t ied in by the funer Certification:	3 Suicida 4 Homicida	6 Could not detarmine	A 288. Ptace	of Injury - At h ng, etc. (Speci	oma, larm, stre	et, factory, office	9		(Street and Number, State)	ber or Rural Route I	Vumber,
he Hospit in 24 hour he Funer pletaly fill edical	29e. Cartifiar (Check only one)	12 Certifying F 2 Medical Ex	miner: On the ba	best of my kno asis of axamina ner stated.	owledge, death ation and/or Inv	occurred at tha estigation, in my	time, date and place opinion, deeth occ	ce, end due to the curred at the time	cause(s) and m , date and place,	anner as stated. and due to the caus	se(s)
To the compound of the compoun	29b. Signeture ar	nd title of certifier				29c. Lice	nse number	1	29d. Data signe	ed (Month, Day, Yes	ir)
	Don	Mosen	rojan (10, Ph	0,	1	05387	-2	11/4	99	
10	30. Nama and ad	dress of person wh	o completed caus	a of death (Iter	n 23a) (Type, f						
	31. Data filed (Mo	Ames ?		Raph	mb,	ho s	DOU Plue	RSIDE DI	2 JAUR	bury mo	
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Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day **Physician** Month 03, HARRY 9:15 PM Τ. VINCENT NOV. 1999 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 6. Sex 2 F If Under 1 Year if Under 24 Hrs. 8. Date of Birth Year 1918 Birthpiace (State or Foreign NORTH CAROLINA 7. Age (In yrs. last birthday) Funeral Days 156-10-5274 81 Yrs. Director Usual Residence of Decedent the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show must be notified at N/A N/A WASHINGTON, D.C. Director X1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 4316 19TH PLACE N.E. Items 23e 20018 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1946 XIX Yes 2 No If Yes, Give to Year or Dates: 1949 Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status the Medical Examiner 1 Never Married 2 Natried ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNO Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: AFRO-AMERICAN "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiane. marked other than Elementary/Secondary (0-12) Coilege (1-4or 5+) TEACHER (D.C. PUBLIC SCHOOLS) EDUCATION 12TH Tent of Health and Mental Hy nt: If Item 27 Is marked other y or other trainman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN VINCENT HATTIE LENA COMPTON 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN S. VINCENT/WIFE 4316 19TH PL. N.E., WASHINGTON, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Suriai 2 Cremation 3 Remove from State permit. Page Department of Important: If eny Injury or LINCOLN CEMETERY NOV. 09, 1999 BRENTWOOD, MD 5 ☐ Other (Specify) 4 Donation 21. Signature of Line Service Ligens 22. Name and Address of Facility
DUDLEY FUNERAL HOME MT. RAINIER, MD 20712 EDWARD M. DUDLEY 3200 RHODE ISLAND AVE., Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical tmmediete Ceuse (Final disease or condition resulting in death) **Examiner** Examiner physician end s tha buriai-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In death) Lest P.O. Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was en autopsy pertormed? Dar accident 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital tal or Attending Physician: The star death.

Is after death.

In Director: After this certificate of in by the funeral director, pa 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 critifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TULI, M.D., 10810 DARNESTOWN ROAD, GAITHERSBURG, MD RAMAN 20078 31. Dete filed (Month, Day, Yeer) NOV 0 8 1999 32 Registrar's Signature State Registrar

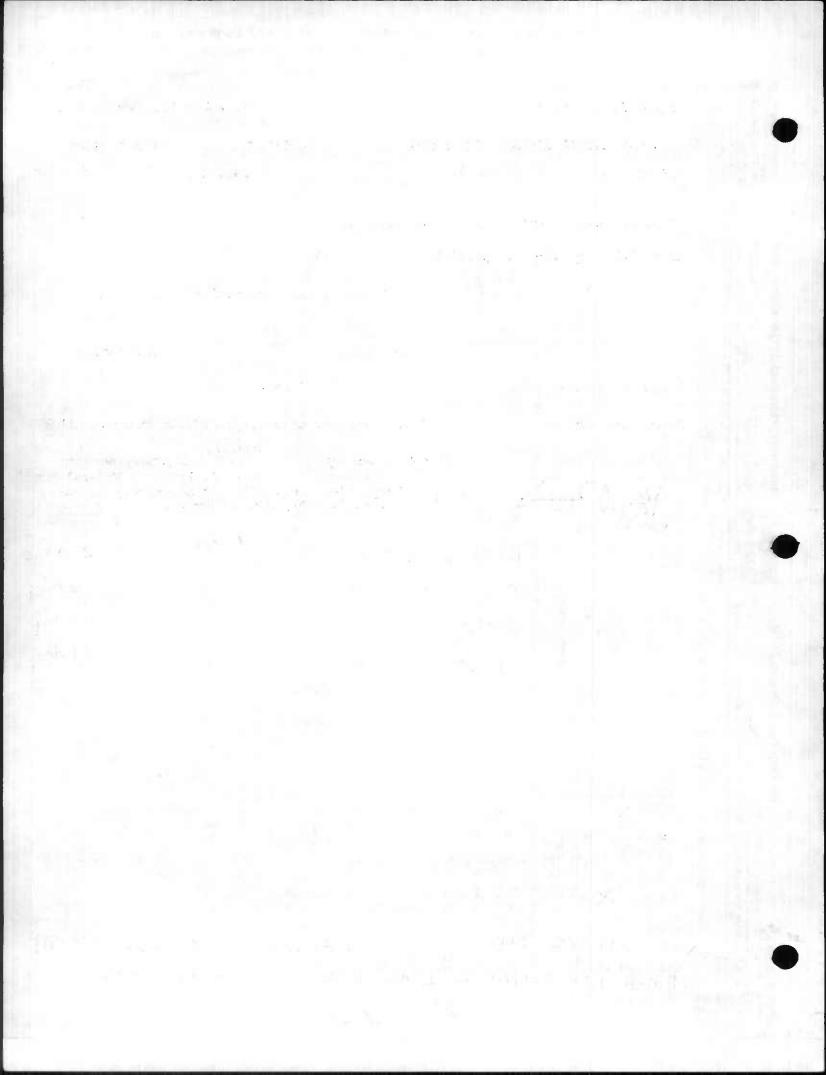
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State of Maryland / Department of Health and Mental Hygiene 99 37543

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an	1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	ath Dev	Year	3. Time o	f Death
cal -	Miguel A. Vallada	res					Novembe	er 15, 1	999	14:1	.2
	4a Facility Neme (If not institution, give	e street and number)			4	4b. City, Town, or l	ocation of Death	4c. County	of Death		
	SHADY GROVE				er 1 Year	ROCKVI	LLE	MON	TGOM	ERY	
	5. Social Security Number 6. S 214-25-2209	#1	(In yes, last bir 81		B Days	Hours Min.	(Month, Da	y, Year)	9. Birthpt Count	Ecua	or Foreig
-	Usual Residence of Decedent		0.1	050	-		Dec. 21	1, 1917		Leua	JUUL
-	10e. Stete 10b. County		10c. City, Tow	n or Location					10	d. Inside C	Ity Limit
to	Maryland Montgom	nerv	Ga	thersb	ure					1 N Yes	2 N
Funeral Director	10e. Street and Number				ip Code			10g. Citizen of V	What Count	lry?	
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eted	15. Decedent's Ed (Specify only highest gra	ducation	16a.	Decedent's Us	vork done	during most of wor	king	16b. Kind of B	usiness/Ind	lustry	
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m	17. Father's Neme (First, Middle, Last))				18. Mother's Nen		, Maiden Suman	18)		
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	19e. Informant's Neme/Relationship (and Number or Ru					000
	Norma Valladares/ 20e. Method of Disposition	wile	20b. Placa o	Disposition (N	ame of	y Circle	Date Date	20c. Location			1 2081
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Examiner	Sequentietty list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		SIS	consequenca o	1):						10.11
edical	that initiated events	C		consequence of	n.				-	20	Tech
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Pa							24a. Was	en eutopsy ormed?	24b. We	re autopsy	findings
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10	exeminer? 1 Pes 2 No	Hospital: 1 tnpatien	t 2 ER/O	utpatient 3 1	DOA Oth	ner: 4 Nursing H	lome 5 Resi	dence 6 Oth	er (Specify	1)	
ü	27. Menner of Deeth 1 ☑Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Day	Year) 28b.	Time of njury	28c. Injur		28d. Describe	how injury occur	red		
cati	2 Accident investigation 3 Suicide 6 Could not be			М	10	Yes 2□No					
Certification:	4 Homicide determined	28e. Ptace of Injurbuilding, etc.	ry - At home, fa (Specify)	rm, street, facto	ory, offica		28f. Location (City or To	Street and Numb wn, State)	ber or Rura	I Route Nur	n <i>ber</i> ,
edical Ce	29a. Certifier 1 Cartifying Ph (Check only one)	nysician: To the best of niner: On the basis of	exemination en	o, death occurre d/or Investigation	ed at the tir	me, date and ptece	, and due to the rred et the time,	cause(s) and madate and place,	anner as st and due to	ated. the cause((s)
-		and manner stet	ea.	2	9c. Licens	se number		29d. Date signe	d (Month.)	Day Year)	
	29b. Signeture end title of certifier										CAG
2	29b. Signeture end title of cartifier	MD			DA	5843		Nosh.	10	3141	499
Σ	29b. Signeture end title of cartifier A C V V 30. Name and address of person who a A M EH A L V A	WD	- t- 40		D 4	5843		Novemb	er 1	511	444

DHMH 16 Ray 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Dey **Physician** NOV. 15, VYCITAL 1999 8:30 PM. MARGARET /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY GAITHERSBURG WILSON HEALTH CARE CENTER Birthplece (State or Foreign Country) If Under 24 Hrs. If Under 1 Ye 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1□M 21XF Director 578-62-1166 93 WASH. DC. 2/25/1906 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at ¥ Yes 2 No Director MD. MONTGOMERY GAITHERSBURG 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20879 U.S.A. 211 RUSSELL AVENUE Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

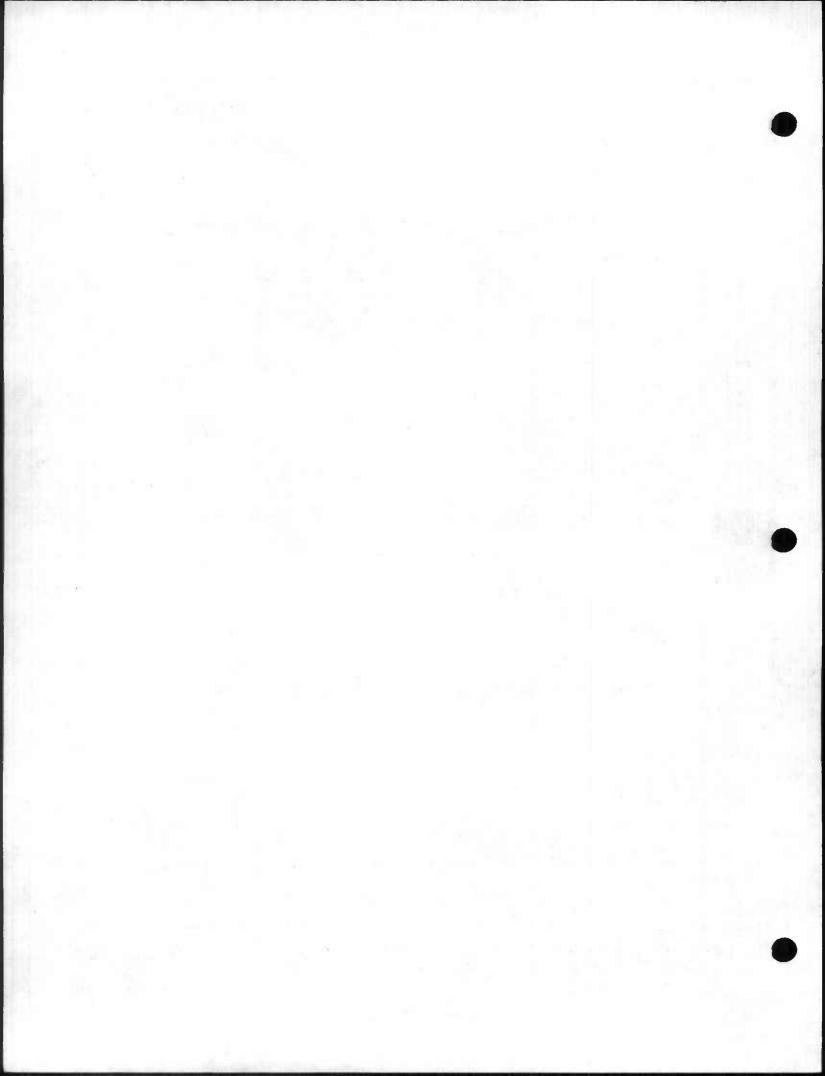
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 14. Rece - American Indien, Black White etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after neat of Health and Mental Hypiene.
neat if them 27 is marked other than "natural", or its mry or other transmitter owns, its waster in its or other transmit. 1 Never Married 2 Merried WHITE 21215-0020 1 ☐ Yes 2 No Specify: Specify p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) EDUCATION TEACHER Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be WINIFERD MCGREGOR JOSEPH M. MICHAELSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 20878 WINIFERD T. REED-DAUGHTER 14211 Dufief Mill Rd. Gaithersburg, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) LINCOLN CEM. 11/22/99BLADENSBURG, MD. 22. Name and Address of Facility
JOSEPH GAWLER'S SONS, INC. 21. Signature of Funeral Service US 5130 WISC. AVE. NW. WASHINGTON. DC. 20016 Pert1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) • DEMENTIA (ALZHEIMER'S TYPE Examiner 3 YEARS Due to (or as a consequence of): Examiner HYPERTENSION physician and the burial-transit YEARS that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 6 3 Probably 4 Unknown 1 Yes 2 No HYPERLIPIDEMIA signed b Records, p 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 TYes 2 No Vital or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) axaminer? 1 AYes 2 No Other: 45 Nursing Home 5 Residence 6 Other (Specify) 2 1 | Inpetient 2 | ER/Outpatient 3 | DOA Division of this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Netural
2 Accident 5 Pending investigation death. 1 Yes 2 No To the Hospital or Attandi within 24 hours after death To the Funeral Director: A completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated. (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) neles D14660 NOV. 16, 1999 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) RONALD GREGOR, 15001 DUFIEF MILL RD. MD. GAITHERSBURG, MD. 20876 31. Date filed (Month, Day, Year) 32. Rygistrar's Signature State

Registrar

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3001 Hospital Drive

Cheverly, MD 20785

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DHMH 16 Rev 6/95

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nd# 26	State of Mai Per Phys. PGC 11-2-99 cr	ryland / Department of F Certificate of	Dooth	giene 99 37547 Reg. No.
Physician /Medical	1. Decedent's Name (First, Middle, Last) Charles Joseph	Wyvill, Jr.	2. Date of Dec Month Oct 31	Day Year 5:37 PM
Examiner	4a Facility Name (If not institution, give street and number) Southern Maryland Hospit		4b. City, Town, or Location of Death Clinton	4c. County of Death Prince George's
Funeral Pirector		(In yrs. last birthdey) If Under 1 Year	If Under 24 Hrs. 8. Date of Birt Mours Min. (Month, De	h 9. Birthplece (State or Foreign
show dat	Usual Residence of Decedent 10a. State 10b. County P.G.	10c. City, Town or Location		10d. Inside City Limits 1 □ Yes 2 No
28a-f shonormost as	10e. Street end Number	Upper Marlboro		10g. Citizen of What Country?
I Dir	14700 Mount Calvert Road	2077	2	United States
by Funeral Director	11. Maritai Stetus 1 Never Married 2X Married 3 Widowed 4 Divorced 12. Was Decedent Evarmed Forces? 1 Yes 2 And If Yes, Giva Year or Dates:	ver in U.S. 13. Was Decedent of Hir Yes, specify Cubin 1 Yes 2	dispanic Origin? (Specify Yes or No an, Mexicen, Puerto Rican, atc.) Specify:	
Completed	15. Decedent's Education (Specify only highest grade complated) Elementary/Secondary (0-12) College (1-4or 5+	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Farmer & Carp	during most of working d)	16b. Kind of Business/Industry Self-Employed
o Re Co	17. Father's Name (First, Middle, Last) Charles Joseph Wyvill, Jr	•	18. Mother's Name (First, Middle, Carrie Jeanette	Maiden Sumame) E Stallings
	19a. Informant's Name/Relationship (Type, Print) Phyllis E. Wyvill, (WIFE) 20a. Method of Disposition IXaurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	14700 Mount C	Date	er, City or Town, State, Zip Code) per Marlboro, MD 20772 20c. Location - City or Town, State Clinton, Maryland
	21. Signature of Funeral Sarvice Licensee	22. Nama and Addra		al Home, Inc 6633 Old
was as the burishment	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury	ue to (or es e consequence of):		Sent few min
M/nei	d			
y Physician/Me	Part II. Other eignificant conditions contributing to death but but any and the second secon	not resulting in the underlying cause gh		tobacco use contribute to the cause of death? Yee 2 No 3 Probably 4 Unknown
Completed by	S/P angin johnt	>	24a. Was perfo	an autopsy med? 24b. Wara autopsy findings eveilable prior to completion of ceuse of deeth?
e Con	The following for 1/9 fixes			Yes 2 No 1 Yes 2 No
To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatien	t 2 ER/Outpatient 3 TOOA Of	28. Placa of Death (Check only oner:	
	27. Manner of Death 1 Naturai 5 Pending (Month, Day) 2 Applicant investigation	Year) 28b. Time of 28c. Injury Wo		how injury occurred
Certification:	4 LI Homicide building, atc.	y - At home, ferm, street, fectory, office (Specify)	28f. Location (. City or To	Street and Number or Rural Route Number, wn, Stata)
edical	29a. Centifier (Check only one) 1.★ Certifying Physician: To tha best of 2 Medical Examiner: On tha basis of e and manner state	examination and/or invastigation, in my o		
7	296. Signature and title of centifier Image: Signature and title of centifier Miles Mil	29c. Licens D - 0	Se number 20824	29d. Date signed (Month, Day, Year)
0/	Name and address of person who completed ceusa of deal of the services of the	ath (Item 23a) (Type, Print) Pun. Ave #18	Appen H	Jun Maco, mm
State Registrar	31. Dete filed (Mcmh, Day, Year) Registrar	's Signature		28772

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State of Maryland / Department of Health and Mental Hygiene 99 37548

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	la Facility Name (#)						cation of Deat		ounty of			
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63	5. Social Security No	umber 6.	5. Sex 1⊠ M 2		ge (In yrs. I	last birthday,	Month:	ler 1 Yaar s Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De	rth sy, Year)		9. Birthple Counti	ace (State ry)	or Foreig
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State of Maryland / Department of Health and Mental Hygiene 37549 Certificate of Death Amend # 31. PGC 11-12-99 cr 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Day Month Year **Physician** Eugenia Rav Walters November 3, 1999 9:30 am /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. H Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 M 2 F Months 220-05-7373 81 Director Oct. 13, 1918 Maryland Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 XYas 2 No Director Maryland | Prince George's College Park 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 238 7505 Hopkins Avenue 20740 U.S.A. Funeral Heme 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 ☐ Yas 2 🕅 No If Yas, Giva Yaar or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 neturel', or 1 Yas 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within Health Education Hygiene. College (1-4or 5+) Elamentary/Secondary (0-12) Grant Administrator Welfare permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If tem 27 Is marked othe eny Injury or other traumatic evant, pages. 17. Fathar's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumema) Be Eugene Walters Ray Earle Marlow 19a. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Virginia W. Pioso - Sister 8332 Verona Drive, New Carrollton, Maryland 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 🖾 Cramation 3 ☐ Removal from Stata 11/05/99 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21 Signature of Funeral Sarvick Licensee 22. Nama and Addrass of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD NUDS. 20781 lbn. 23a. Part. Enter the desease, or complications that caused the plant. Do not antar the mode of dying, such as cardiac or respiratory arrest, mock, or heart entering. Ust only one cause on each line. Approximata Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final PULMONARY disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner attending physicien and for use as the burial-transit certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Diseasa or injury thet initieted events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical the Dua to (or as e consequence of) P.O. Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 N Yes 2 No 3 Probebly 4 Unknown signed b Records, b 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? The law has 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: 25. Was casa referred to medical Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidence 8 Othar (Specify) Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yas 2 No this 28c. Injury et Work? 27. Mennar of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Panding invastigation 1 Natural Injury death. 1 Yas 2 No 2 Accident To the Hospital or Attand within 24 hours after deatl To the Funeral Director: 6 Could not be datarmined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledga, deeth occurred at tha tima, data and place, end due to the ceuse(s) and menner es stated.

2 Examiner: On the basis of axaminetion and/or invastigetion, in my opinion, death occurred at the tima, date end place, and due to the cause(s) and mannar steted. 29a. Certifier edical compietely one) 29b. Signature and tig e or certifian 29c. Licanse number 29d. Data signed (Month, Day, Year) November 8, 1999 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) BELCREST ROAD HYATTSVILLE, MD 20782 MD KELMAN 6525 31. Data filed (Month, Dey, Year) 32. Registrar's Signature State 1 2 1999 08/9 Registrar

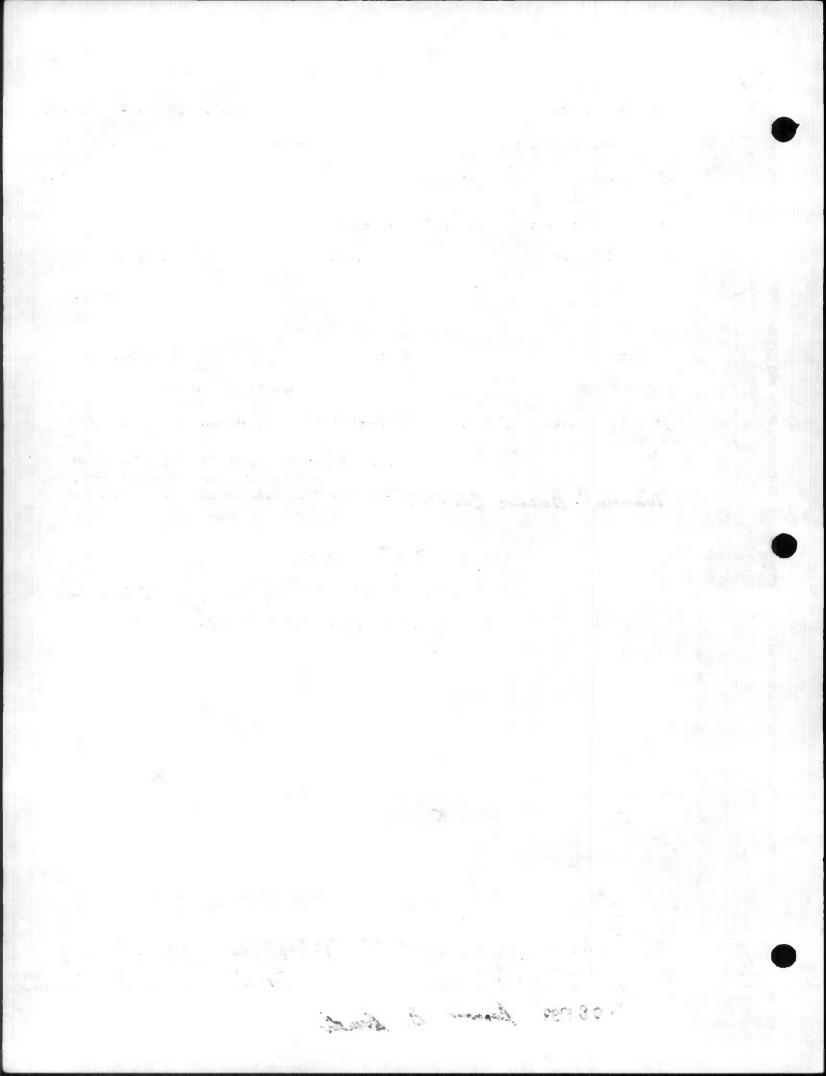
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State of Maryland / Department of Health and Mental Hygiene 99 37550

			C	ertificate	e of	Death		Reg. No.) (0/000
	1. Decedent's Name (First, Middle, La	st)					2. Date of De	ath	Vess	3. Time of Death
Physician /Modical	Ora Bell Watkin	S					October	Day 29, 1	Year 999	4:10 PM
/Medical Examiner	4e Facility Neme (If not institution, give				- 4	4b. City, Town,	or Location of Deat		nty of Death	
	Prince Georges Ho	spital				Chever1	v	Prin	ce Ge	orge's
Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs	. last birthde	y) if Under	1 Yeer	if Under 24 H	rs. 8. Date of Bi	th		place (State or Foreig
Director	579-24-3594 Usuel Residence of Decedent	□M 2\XF 86	Yrs	Months	Days	Hours M	in. (Month, De 02–29-			h Carolina
filed within 72 hours after death with the Merylend Hyglene. Ifther than natural', or items 23a or 28e-f ahow ant, the Medical Estatute must be inclifted at e Completed by Funeral Director	10a. State 10b. County	10c. C	ity, Town or	Location						10d. Inside City Limit
Mer to	Md. Prince G	enroe's Ca	nitol	Height						1 N Yes 2 N
ifer death with the Me r ferms 23a or 28a-fa front must be notified Funeral Director	10e. Street and Number	COIGC D OC	PICOI	10f. Zip				10g. Citizen o	of Whet Cou	intry?
3a o	119 West Mill Ave	nue		207	43			U. S	Α.	
Der F	11. Maritel Stetus	12. Wes Decedent Ever in U	J,S. 1			Ispanic Origin?	(Specify Yes or No erto Rican, etc.)		lace - Ameri	
Thesity and Strouto as they within 12 hours after death with the weiven if the sith and Mentel Hyghen. If the sith and Mentel Hyghen. Other traumatic event, the Medical Evantives must be notified at the sith and	1 Never Married	Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates:		1 Yes, speci	161	Specify:	eno Hican, etc.)	Spe	lack, White	lack
te patrici	15. Decedent's Ed	Jucation	16a. De	cedent's Usua	Occup	ation		16b. Kind of	Business/Ir	ndustry
ygiene. ner than 'naturint, the Medical.	(Specify only highest gra	de completed) College (1-4or 5+)	(G.	ive kind of wor e. DO NOT us	k done e retired	duning most of v	vorking			
E .	6th	College (1-401 5+)	Cl	nef				Food	Serv	ice
d other	17. Father's Neme (First, Middle, Last)					18. Mother's N	lame (First, Middle			
Mente	Arthur Clark					Bess	ie Wilson	1		
marked of umatic every	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address	(Street		Rural Route Numb		vn, Stete, Zi	ip Code)
and 2 see and 2	James W. Padgett	Son					. Washing			
Hoo	20a. Method of Disposition	20b.		sposition (Namerematory or of			Date	20c. Locatio		
nent of I	1 CyBurial 2 Cremation 3 C	Hemoval from State	cemetery, o	crematory or of	ther plea	00)				
ury ury	4 Donation 5 Other (Specify) F	ort L:	incoln			11/6/99			
Department of Hee Important: If frem any injury or othe once.	21. Signature of Funeral Servica Licen	S 00		22. Name end	d Addre	ss of Facility	W.H. Baco	n Fune	ral H	ome, Inc.
RSESS	Malanda C. B.	acon CC 3	21-13	3447 14	th	St., N.	W. Washir	ngton,	D.C.	20010
	23a. Pen1. Enter the diseese, or com- shock, or heart failure. List only	plications that caused the dea							- 1	Approximate
new requires that the been common be executed the steep section and a 2 should be deteched for use as the burial-transit and private section of the provided by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Lest	c. Aty	or as a con	sequence of):	0	25te	ro(e	Dis	eas	le_
d by the attendin eteched for use Physician/N	Part II. Other eignificant conditions or	dontributing to death but not re-	sulting In th	e underlying ca	ause giv	ren in Pert I.	23b. Did	tobacco uee	contribute	to the cause of deat
by the steech							10	Yes 2 N	o 3□ Pro	obebly 4 Unknow
gned be de be de										
should should				***				an eutopsy ormed?	a	Vere autopsy findings vailable prior to completion of cause of deeth?
page 2							10	Yes 2 No		
or, pe	OF Means of and a decided								1	☐ Yes 2☐ No
is certificate he director, page	25. Was case referred to medical exeminer?	Hospital:	_		Oth	er.	Death (Check only			
ter this certific unerel director.	1 Yes 2 No 27. Manner of beath 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpa 28b. Time Injur	e of 28	Bc. Injur	4 LI Nursin	g Home 5 Res			eify)
ector: After by the fune iffication	2 Accident investigation	- /		М	1 🗆	Yes 2□No				
rs effer death. sl Director: Affer t led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa of Injury - At It building, etg. (Spec	nome, farm,	street, factory	, offica			(Street end Nu wn, State)	mber or Ru	ral Route Number,
C e D e										
Funer Funer lely fil	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kn- niner: On the basis of examin- and manner stated.	owiedge, de ation and/or	eath occurred a r Investigation,	at the tir in my o	me, date and ple pinion, death o	ece, end due to the ccurred at the time	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)
within 2 To the comple	29b. Signature end title of certifier	1/		29c.	. Licens	e number		29d. Date sig	ned (Month	Day, Year
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6	30 Name end eddress of person who	completed cause of death (Ite	m 23a) (Ty	pe, Print)	:1	12	Chev	1	M1	1/2 00
	(4) ex Jaso	n///30	101	MOSP	1/6	U Dr	: Unev	2110	1119	. 2018
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Registrar	MON B R JOSC	Balance	A	-		r*		,		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Sharen Lynn Ward November 7, 1999 10:40 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Healthcare Center Adelphi Prince George If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 280 F 216-44-5273 Yrs 53 Director Apr 14, 1946 Washington, DC Usual Residence of Decedent Mandend 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Prince George Director MD Lanham the s 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? with 7217 Cipriano Springs Drive 20706 USA death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck. White, etc. filed within 72 hours effer 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Maryland Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important if them 27 is married other tha. Government. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be June Loraine Griffith William Elwood Fowler 19a. Informant's Name/Reletionship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas T. Ward / Husband 7217 Cipriano Springs Drive, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removet from Stete 4 ☐ Donation 5 ☐ Other (Specify) Nov 11 Prospect Hill Cemetery Washington, DC 1999 21. Signature of Experial Service License 22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate Approximete Intervel Between Onset end Death **Physician** /Medical date Cause (Final disease or condition resulting in death) Examiner Examiner I or Attanding Physician: The law requires that the death certificate be associted eftar death.

Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be deteched for use as the burist-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tas Division of Vital Records. A 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Hypertension 1 Yes 212 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicat examiner?
1 ☐ Yes 2 ☑ No 8 26. Place of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Naturat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 I Homicide Mospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Cartifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Dete signed (Month, Day, Year)

State Registrar ORE MD 4203 Queenstoury tel Hyattsville MD 2078

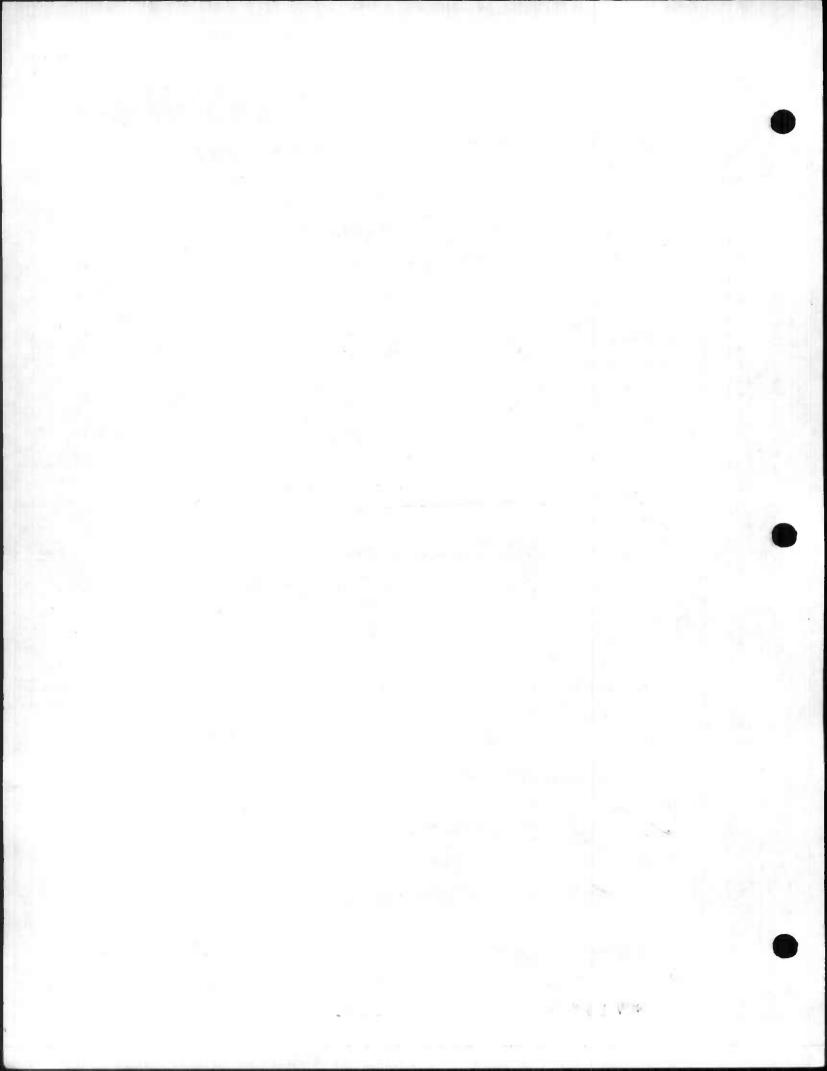
Name and address of person who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

DE

NOV 1 9 1999

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene George Buroughs Wittig, Jr.

37552

Physician
/Medical
Examiner

Funeral

Director I show

"natural", or flems 23a or 28a-f ehord cal Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: If Ifem 27 ie marked other than "natural", or fle eny injury or other traumatic event, the Medical Examina

Saltimore, Maryland 21215-0020

be executed 68760 Box P.O. Records, sign be Division of Vital Hospital or Attending Physician: director this funeral After death.

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month George Burroughs Wittig Jr November 12, 1999 2:25 A.M. 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 2551 Stone Road Westminster Carroll If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (fn yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days (X) M 2 F Yrs. 212-50-2022 52 Oct MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2551 Stone Road 21158 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry G.B. Wittig HVAC Elementery/Secondery (0-12) College (1-4or 5+) Owner Services Inc. 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Burroughs Wittig Sr Virginia Weddle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) 2551 Stone Road Judith Wittig/wife 21158 Date Westminster, MD 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Meadow Branch 11/16/99 Westminster, 4 ☐ Donetion 5 ☐ Other (Specify) re of Funerel Service L 22. Name end Address of Facility
Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 Lenter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ik, or heart failure. List only one cause on each line. Approximete triterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Intraoral Gunshot Wound Examiner Due to (or as e consequence of): Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes XX No ģ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? Inspection 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1⊠ Yes 2□ No 28a. Dete of Injury Fou(Magrit, Dey Year) 11-12-1999 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Found: 12:45 A 1 Neturel 5 Pending 1 Yes 2 No investigetion Subject shot self. 2 Accident 24 hours after deaf Funeral Director: 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2551 Stone Road, within 24 hours after de To the Funeral Directo completely filled in by the Hame. Westminster, Maryland. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number O.C.M.E. November 13, 1999 Ouras

State Registrar

31. Dete filed (Month, Day, Year) NOV 1 5 1999

Margarita Korell M.D.

32. Registrer's Signature

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

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State of Maryland / Department of Health and Mental Hygiene 99 37553

			Cei	rtificate of	Death	R	eg. No.		
	1. Decedent's Name (First, Middla	, Last)	1111			2. Data of Dea		V	3. Time of Dear
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/Medica	A. Franks, Name of Continues in a structure				4b. City, Town, or Lo		4c. County	of Death	
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Funeral			rs. last birthday)	If Under 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day)	Year)	9. Birthpl	laca (Stata or For
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100	MD Mont	gomery S	ilver	Spring					1 ☐ Yes 🏌 🗆
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Hygiene. ther than "natural", or items 23s ant, ma Mesical Examiner must	11. Marital Status	Armed Forces?	10,5.	If Yas, specify Cub	an, Mexican, Puerto	Rican, etc.)		ck, White,	
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yglene. Ner than "natur it, the Medical	15. Decedent (Specify only highes	's Education	16a. Dece	dent's Usual Occup	pation during most of work id)	ina	16b. Kind of B		•
	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)				curity
the Man	10	0011030 (1 101 01)	Cl	erical			Admin	istr	ation
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nerke nerke			405 84500	an Andreas (Classe)		Bankar		Ctata Tia	Codel
if Health and Mental hygiene. Item 27 is marked other than other traumatic event, the M	19a. Informant's Name/Relationsh	nip (Type, Pnnt)			tand Number or Run Ct Balti				COG6)
n 27	Virginia With				Co Balt.				
P P P P P P P P P P P P P P P P P P P	20a. Method of Disposition		o. Place of Dispo cemetery, crei	sition (Name of metory or other pla	ice)	Date	20c. Location	- City or To	wn, Steta
y or	M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		eysvil	le Ceme	tery	11/12/9	9 Key	svil:	le, MD
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/Medical	Immediate Cause (Final	Caroli	· Resp	unates	, Augo	ch		1	so hom
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in Dire	4 Homicide	building, etc. (Spe	ecity)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	n, State)		
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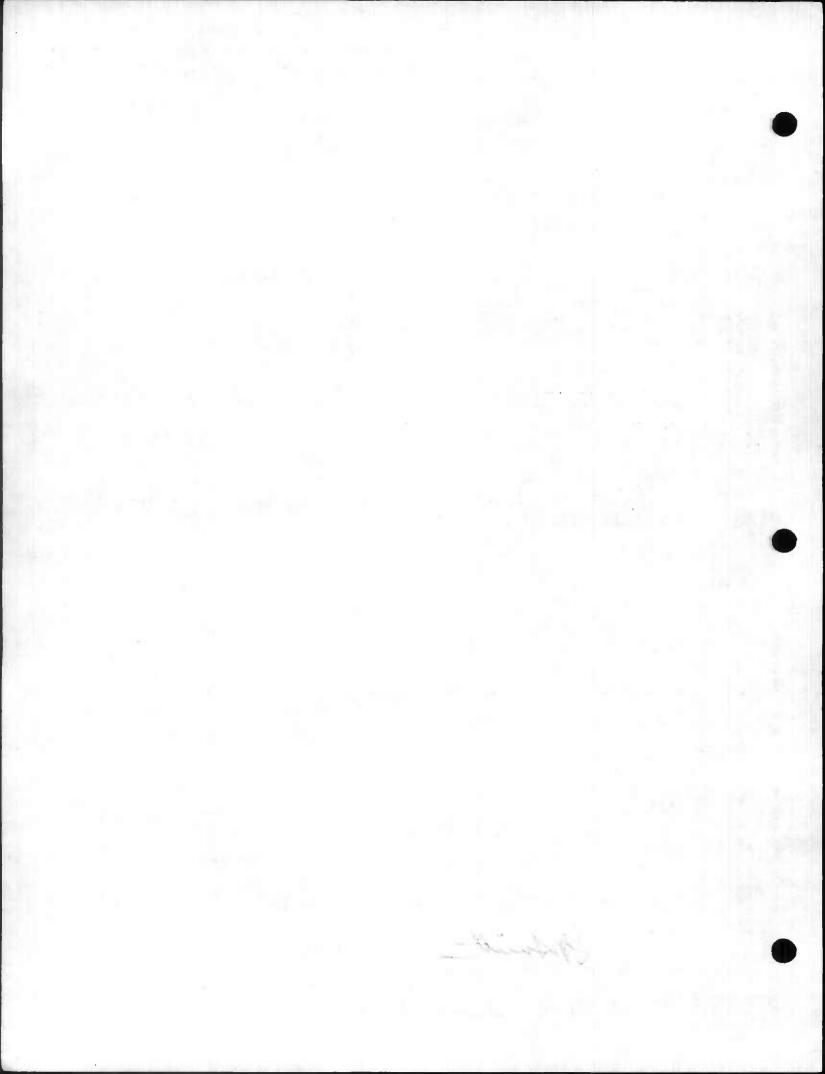
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State of Maryland / Department of Health and Mental Hygiene 9 9 37554

	Certificate of Death Reg. No.								1004	
	1. Decedent's Name (First, Middle, Li				Month	2. Date of Death Month Day Y		3. Time of Death		
	Betty Christ						ber 12,1		10:00 A	
	4a Facility Name (If not institution, give					n, or Location of Dea				
13605 Autumn Trail Drive Germantov 5 Social Security Number 6 Sax 7 Ang (In yrs lest hirthday) fl Under 1 Year ff Under 24 Hrs.							0			
5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last bit 67			Yrs.	Months Days		Min. 8. Date of Br (Month, D July		9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent 10a. Stata 10b. County	10c. C	ity. Town or L	ocation				100	1. Inside City Lim	
		10c. City, Town or Location Supply					1 □ Yes 24 ⊋N			
	N.C. Brunsv									
245 Club House Drive				10f. Zip Code	28462			10g. Citizen of What Country? United States		
ŀ	11. Marital Status									
1 Never Married 2 Married 3 DWidowed 4 Divorced		Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Datas:		13. Wes Decedent of Hispanic Origin? (Specify Yes o II Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ☐ No Specify:			Black, White, etc. Specify: White			
15. Decedent's Edu		ication 16a. Decedent's U		dent's Usuel Occu	Usuel Occupation		16b. Kind of Business/Industry			
(Specify only highest grad		le completed) (Give kind o. lifa, DO NO		e kind of work done DO NOT use retire	d of work done during most of working					
Elementary/Secondary (0-12)		Cotlege (1-4or 5+) Home		emaker			Own Home			
	17. Father's Nama (First, Middle, Last	18. Mother			s Nama (First, Middle	Nama (First, Middle, Maiden Surname)				
Lacy H. Christie				Hallie Marie			Fullen			
19a. Informant's Name/Reletionship (Type, Print)			19b. Meil	ing Addrass (Stree	nber, City or Town, Stata, Zip Code)					
							A 22180			
	20a. Method of Disposition		Plece of Disp	osition (Neme of		Date	20c. Location -	City or Tow	n, Stete	
	1 ☐ Burial 2XDCremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			cremetory or other place) litan Crematory		Nov 12, 1999	Alexandria, Virginia			
21. Signature of Funeral Service Licensee 22. Name end Address of Facility De Vol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD							D 20877			
	shock, or heart lailure. List only Immediate Cause (Finet disease or condition resulting in death)	one cause on each line. HEPATOMA	НЕРАТОМА					Approximate Interval Between Onset and Deat		
		Dua to (or as a consequence of):								
	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury	Due to (or es e consequence of):								
that initiated events resulting in death) Last		C. Due to (or es a consequence of):								
						1				
	Part It. Other significant conditions of	ulting in the underlying cause given in Part I. 23b.				Did tobacco use contribute to the cause of death?				
					1	1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknow				
							24a. Wes an autopsy performed? 24b. Were autopsy linding available prior to completion of cause of death?			
ı						10	Yes 2 No	10	Yas 2□No	
ı	25. Was case referred to medical				26. Place o	of Death (Check only	one)	l		
	examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) house								
	27. Manner of Death	28a. Data of Injury 28b. Time of 28c. Injury at 28d. De					how injury occurr		nouse	
	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation									
	3 Suicide 6 Could not be detarmined					28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
		ysician: To the best of my kn niner: On the basis of examin and menner stated.								
ı	29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Year)			
	> Muit			D33293			November 12, 1999			
itate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Pearson Smith, M.D., 5401 Western Ave., N.W., Washington, D.C. 31. Date filed (Magnin Day, Year) 1000 32. Pygistrar's Signeture									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10, Florry В. Weening Nov. 1999 2:40 AM /Medical 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Spring House at Westwood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF Yrs. Director 93 063-22-2981 May 25, 1906 The Netherlands Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rs 23s or 28s-f short must be notified at Md. Bethesda Yes 2 No Montgomery Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or flares 23s or 5101 Ridgefield Road 20816 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. after ☐ Yes 2 No Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white 3 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) filed within Hygiene. Elementary/Secondary (0-12) trader currency exchange 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be h and Mental F Is marked of 8 Leentje Speijer Salomon deJong Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a Elizabeth Cook/Daughter 1661 Crescent Pl., N.W. Wash., D.C. 20009 #406 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State mportant 4 ☐ Donation 5 ☐ Other (Specify) Nov.11,99 Metropolitan Crematory Alexandria, Va. DeVol Funeral Home 2222 Wisconsin Ave 21. Signature of Funeral Service License 22. Name and Address of Facility Washington, D.C. 20007 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or hear failure. List only ona ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Non-Hodgkins Lymphoma 28 Months disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy tindings evaileble prior to been si Completed 24a. Wes an autopsy performed? completion of cause of death? pege 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after deeth.

To the Funeral Director; A completely filled in by the fu deeth. 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and the of certific 29c. License number 29d. Dete signed (Month, Day, Year) Nov. 10, 1999

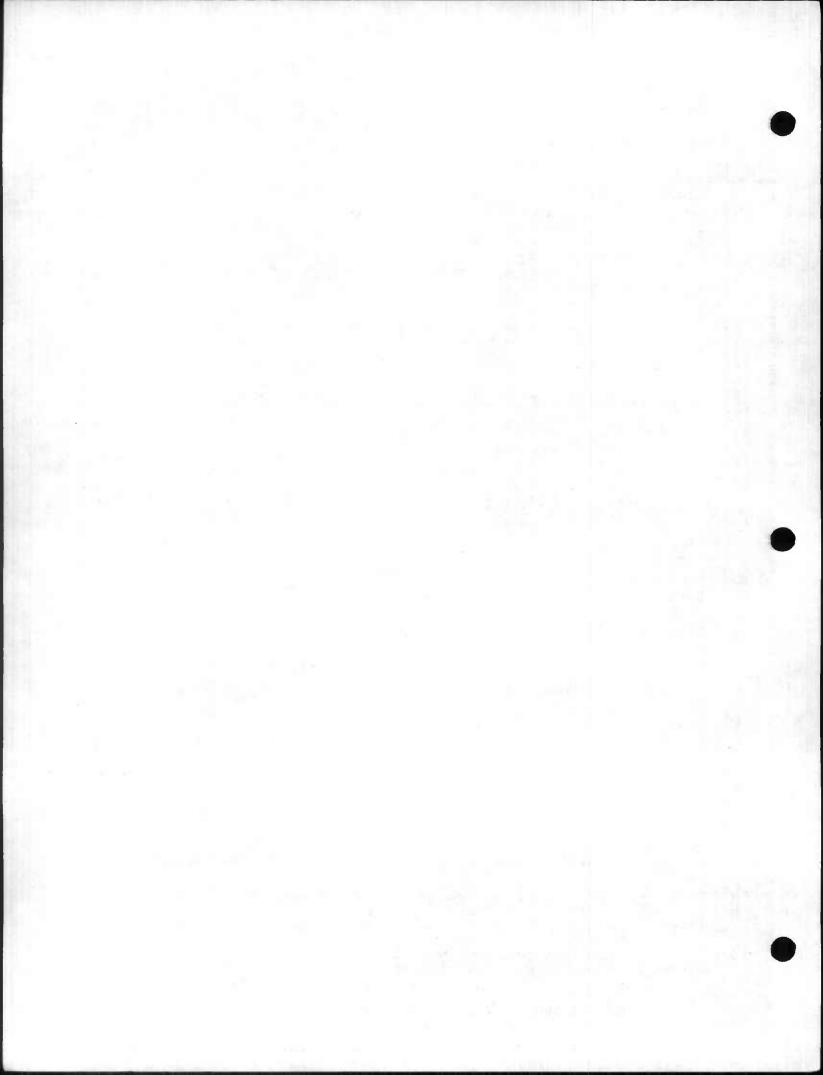
Lee Pennington, M.D. 31. Date tiled (Month, Day, Year) NOV 1 6 State 16 Registrar

5602 Shields Drive Bethesda, MD 20817-3571 32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1999

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Physician /Medical Examiner

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The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Physician

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if them 37 is marked other any injury or other traumatic event, once.

the Medical Examiner must be notified at

death with the Meryland

filed within 72 hours after

21215-0020

altimore, Maryland

Examiner been signed by the attending physician should be detached for use as the buria Physician/Medical þ Be Completed within 24 hours after death.

To the Funeral Director After this newstare. Certification: To

2 NO 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminer? 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant 1 Yes 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 ER/Outpatient 3 DOA 28a. Data of injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Netural 2 Accident 5 Pending 1 Tes 2 No invastigetion 6 Could not be determined 3 Sulcida 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 D Homicida 29a. Certifiar (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and plece, end due to the cause(s) end mannar es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, deta and plece, and due to the cause(s) and mennar stated.

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29c. License number 41926 29d. Date signed (Month, Dey, Year) 15

30. Nama and addrasa of person who completed causa of death (Itam 23a) (Type, Print)

Connecticut Ave Kensington Md 10810 MD A. OATES 31. Data filed (Month, Day, Year) 32. Registrar's Signatura NOV 1 6 1999

State Registrar

Medical

29b. Signetura and titla of certifier

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Charles M. Connect Server

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 1999 7:22 PM Lester Whitacre November 14, 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number, 4c. County of Death Prince George's Hospital Regional Laurel Laurel 8. Date of Birth (Month, Dey, Year) Country, Cont. 14,1925 West If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6 Say Min. Days tom 2□ F Months Hours 74 216-22-5930 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 1 Yes 2 TNo Burtonsville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3001 20866 United States of America Winifred Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 200 Married 1 Yes 2K No Specify: 43-146 Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor U.S. Government 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Harry Whitacre Edith Branson 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Burtonsville, MD June C. Whitacre/Spouse 3001 Winifred Drive 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/19/99 Triangle, Virginia Quantico National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fuheral Service Lice Hines-Rinaldi Funeral Home, Inc Silver Spring, MD 20904 11800 New Hampshire Ave. of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ast only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Fig. ars resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initioted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of geath? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ★ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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? Is marked other than "naturel", or items 23s or traumatic event, the Medical Examinar must be

Pages 1 and 2 should be filed within 72 hours efter death hant of Health and Mentel Hygiene.

Health Hem 27 I

E 6 Department of important: If any injury or once.

Baltimore, Maryland 21215-0020

Director

Funeral

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Examiner physicien end the burlei-transit Physician/Medical for use as ed by the deteched signed by t þ should Completed Be Certification: To

The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, certificate hes t or Attending Physician: director, this funeral death. after death Director: A

Hospital

within 24 hours aft To the Funeral Dis completely filled In Medicai the th AN 10

1 Netural

2 Accident

3 ☐ Suicide

29a. Certitier

29b

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4 Homicide

State Registrar

Injury

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Yes

2 No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) NOV 19 1999

5 Pending investigation

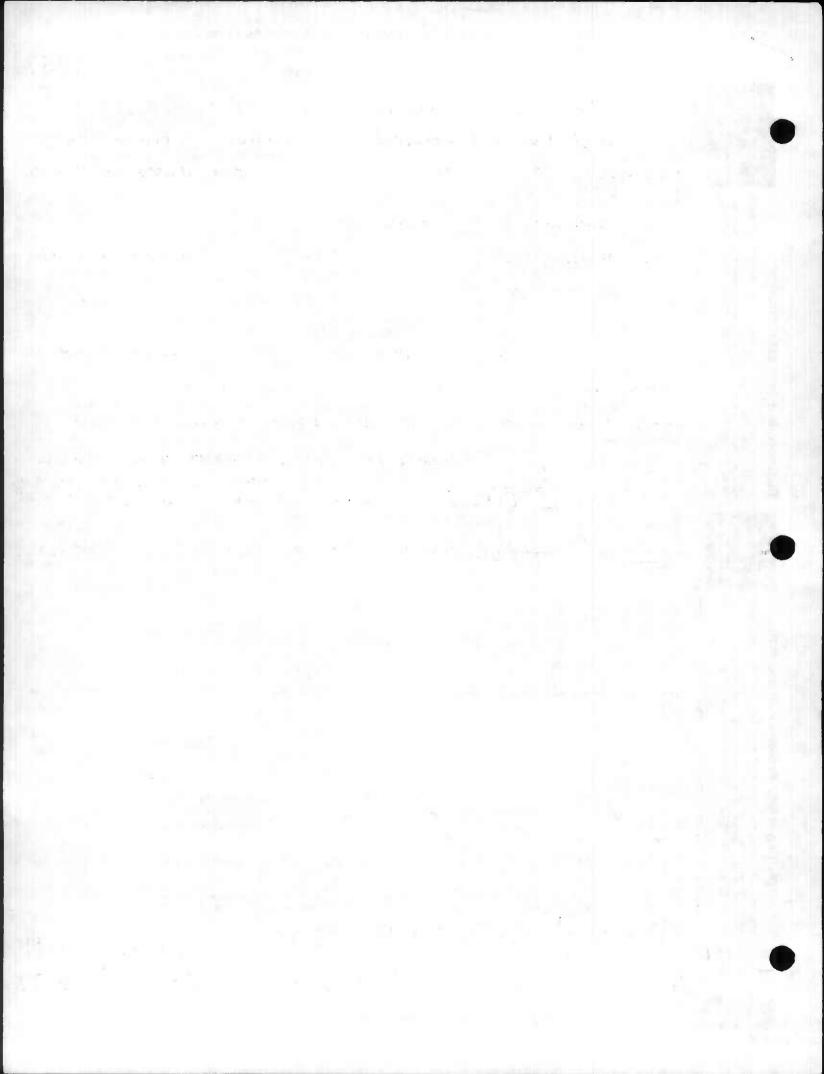
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2 ☐ Medicat Examin

and title of certified

32. Registrar's Signature

#328, OLLEY



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

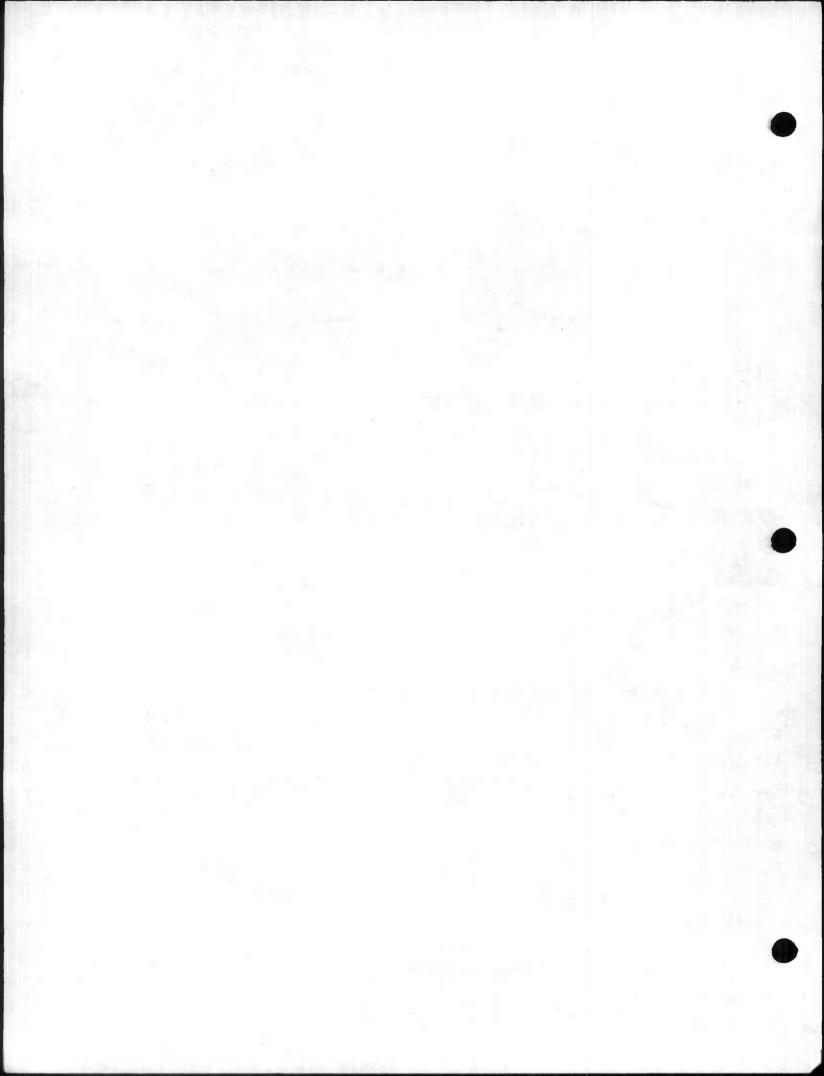
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** NOV. Year 100 Burnette L. White 1999 1:02 AM /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Dete of Birth
Jan Per 1 7,1922

9. Birthplaca (State or Foreign
2 Frederick MD 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months 205-18-16031 M 20F 77 Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits show Prince Georg's Hvattsville 1 X Yes 2 □ No Director 28a-f 10e Street and Number 10f Zin Code 10g. Citizen of Whet Country? Berns 23a or 20782 USA 2008 Van Buren Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No It Yes, Give 1 Never Married 2 Merried natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Home Maker Private 11th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important. If them 27 is marked oth, any Injury or other traumatic event policie. 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be Lillian Stanton Lissac Stanton 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2008 Van Buren St., Hyattsville, MD 20782 Sharon Brunson 20b. Pleca of Disposition (Neme of cemetary, crematory or other plece)
Maryland Veterans 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 11-19-99 22. Neme end Address of Facility 21. Signeturi al Funerel Service Licens 3831 Georgia Ave, NW, Wash., DC Latney's Funeral Home 20011 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximeta Intarvel Between Onset end Deeth **Physician** Sepsis /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medicai Due to (or as e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yss 2 No 3 Probably 4 Unknown Carcinoma bengis be det Records, à 24b. Were autopsy tindings aveilable prior to Be Completed 24a. Was an eutopsy completion of cause of death? page 2 1 ☐ Yes 2 → NO 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case reterred to medical director 26. Place of Deeth (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) à 4 Homicide within 24 hours after To the Funeral Dire completely filled in b edical 29s. Certifier 16 Cortifying Physician: To the best of my knowledge, daath occurred at tha time, date end place, end due to the cause(s) and manner as stated. (Check only one) 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end dua to the cause(s) end menner steted. 5 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ohallem 842578 NOU 10, 1999 30. Name and eddrass of person who completed causa of death (Item 23a) (Type, Print)

GW CHABLANI, 11119 Roubevult PIKE # 401, My20852 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture State NOV 1 8 1999 books Registrar

DHMH 16 Rsv 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Yee Month **Physician** Nov 5 1999 5:55 AM Mary D. Waters /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Easton Talbot Genesis ElderCare -The Pines If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Yeer) if Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Deys 1□M 200 F 155-14-0082 106 Nov. 18, 1892 Maryland Director Usuel Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Caroline Preston 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 4139 21655 Harmony Road USA permit. Pages 1 and 2 should be filed within 72 hours after deeth Department of Health end Mantel Hyglene. Important: if item 27 is marked other than "naturel", or items 23s eny injury or other treumstin average. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0020 1 Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced Yeer or Dates: **Black** Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Someone else's Home Homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Peter Dotson Virgil thomas 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Name/Relationship (Type, Print) Mary Sharp, Niece 4139 Harmony Road, Preston, Maryland 21655 altimore, 20c. Location - City or Town, Stete 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) Date 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 11/19/99 Hurlock, Maryland Washington Cemetery 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee P.O.Box 1687, Easton, Maryland 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** Mulmonary edema Immediate Ceuse (Final disease or condition resulting in death) /iviedical Examiner Examiner ettending physician end for use as the burial-trensit thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury ronam Physician/Medicai thet initiated events resulting in deeth) Lest Due to (or es e consequence of) BS sclerosis enerale 10ANS 23b. Did tobecco use contribute to the ceuse of death? Part fl. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No are brovascular in sufficience signed t Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy Completed peen certificate has 1 Yes 2 No gremia 1 ☐ Yes > No Hospital or Attanding Physician: 25. Was case referred to medical exeminer? funaral director, Be 26. Place of Deeth (Check only one) 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 After this 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury et Work? Certification: 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No death. 2 Accident aftar death 6 Could not be determined Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a, Certifier completaly (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

State Registra

ROWLLY

32. Registrer's Signeture

31. Date filed (Month, Day, Year)

Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37561 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day November 6, 1999 pation of Death 4c. County of Death WALLER 0610 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2K) F Yrs. 214-30-8466 JUNE 25,1914 MARYLAND Usual Residence of Decedent 10b Counts 10c. City. Town or Location 10d. Inside City Limits Yes 2 No WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 U.S.A. 436 W. MONTICELLO AVE. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE DIRECTOR COUNTY HEALTH DEPT. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) MINNIE P. WATNWRIGHT FLLIS 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM H. WALLER, JR. - SON 27802 SILVER RUN LANE SALISBURY, MD 21801 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removel from Stete PARSONS CEMETERY 11/10/99 SALISBURY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens, 22. Name end Address of Facility 705 E. MAIN ST. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. SALISBURY, MD 21804 Approximete Intervel Between Onset and Death Immediate Cause (Final DM MYOURDIN INFARITION Due to (or es e consequence of): CORONARY Y comes DIAME MRT. Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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After

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To the Hosp within 24 hor To the Fune completely fi

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Certification:

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Funeral

Director

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72 hours after

Baltimore, Maryland 21215-0020

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Division Attending Directo

Funeral

by

FLORENCE

10a State

MARYLAND

11 Marital Status

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J.

MERVIN

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

disease or condition resulting in death)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

DISONSE (HOMO DIALYTIS Farmer / CARDIO MY OPATHY

1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed?

26. Place of Deeth (Check only one)

24b. Were autopsy tindings available prior to completion of cause of death?

HYLER TONILON

EHO STHEN ROMA

MATHAITIS Hx POUO

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

CONCESTIVE

1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

120001

Hospitel:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number D44069 29d. Date signed (Month, Day. Year) 11.6.99

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

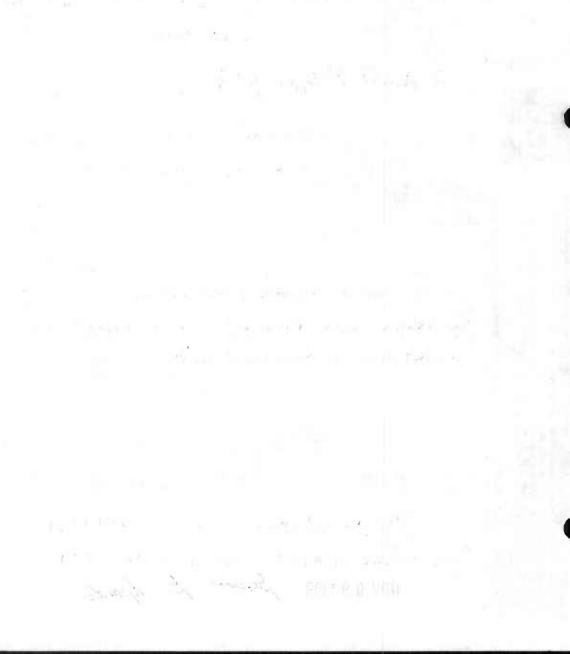
21804

State Registrar

31. Date tiled (Month, Day, Year) 9 1999 32. Registrer's Signeture

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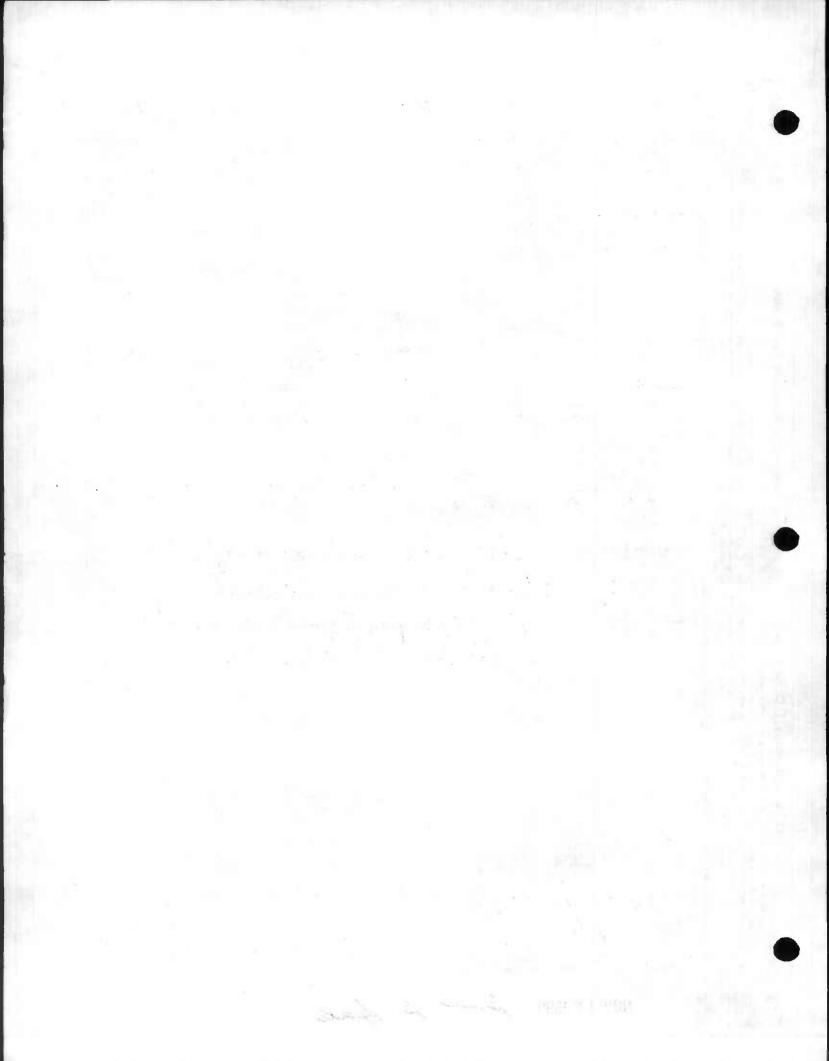
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State of Maryland / Department of Health and Mental Hygiene Q Q

					Certifica	ate of	Death		F	leg. No.)	1302
		1. Decedent's Name (First, Middle, La	ist)						2. Date of Dea			3. Time of Death
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	ledical aminer	4a Facility Name (If not institution, give		***			4b. City, To	wn, or Lo	cation of Death	4c. Count		2.43 All
EX	anuner	27021 N. Tourma					Hebr	on			comic	70
				(In yrs. last birth	day) If Un	der 1 Yaar			8. Date of Birth			
Fune			Du and	52 Y	Month			Min.	(Month, Day	, Year)		laca (Stete or Foreign ntry)
Direc	loi	Usual Residence of Decedent)			1		October :	10,1947	Lou	siana
pue &	15	10a. Stata 10b. County		10c. City, Town	or Location						1	Od. Inside City Limits
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ours our	d by	3 Widowed 4 Divorced	Year or Dates:							Ороси	,.	
21215-0020 d within 72 hours af plane. ir than "natural", or	Completed	15. Decedent's E (Specify only highest gro	ducation	16a. D	ecedent's U	sual Occu	pation during most	t of worki	ina	16b. Kind of B	usiness/Ind	Justry
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N Met	Ö	12	4	Ent	forcem	ent A	Agent			Child	Suppo	ort
	Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Meiden Sumer	ne)	
d d d d d d d d d	10	Carl Brown					Ma	rie	Franks			
Maryland Id 2 should be flight th and Mentel H; T is marked oth	Ē _	19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Addre	ess (Street	t end Numbe	er or Rure	al Route Number	r, City or Town	, State, Zip	Code)
Z = Z	5	William M. West/	Husband	2	7021 N	. Tou	rmali	ne D	r., Heb	ron, MI	2183	30
0 - F E	É	20a. Method of Disposition		20b. Place of C	Disposition (f	Vame of		1		20c. Location		
Page Hr.	6	1 ☐ Burial 2 ☼ Cremation 3 ☐			cremetory o							
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2026	• a	David A.	(Bomos	TO OT					Salisb			
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, a d	3	Part II. Other significant conditions of	contributing to death but	not resulting In t	he underlyin	g cause gi	ven in Part I.	,	23b. Did to	obacco use co	entribute to	the cause of death?
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or Attending attached to the	1	2 Accident investigation			M	1	Yes 2 🗆	No				
A C C C		3 Suicide 6 Could not b 4 Homicide determined	9 28a. Place of Injurbuilding, etc.	ry - At home, fam	n, street, fact	ory, office			28f. Location (S City or Tow		ber or Rura	al Route Number,
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主芸匠を	edical	(Check only 2 Medical Exam	niner. On the basis of a	examination and/	or investigati	on, in my	opinion, deal	th occurr	ed at tha time, d	lata and place,	and due to	tha cause(s)
To the He within 24 To the Fe	Me	29b. Signature and title of begittier	1			29c. Licen:	se number		2	29d. Date signe	ed (Month,	Dey, Year)
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		1,400	w			0	11-1	//		11/10	117	/
	10	30. Name and address of person who										
	10	Dr. Clifford Whe		207 W	. Vine	e St.	, Sali	sbur	cy, MD 2	21801		
	State	31. Date filed (MRTO Pay, Year) 19	99 32. Registra	's Signature	9	6						
Red	istrar				. 10	Oak	1					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 99

		State of Maryla		tificate of		Re	g. No. 99	37563
Physician /Medical	Decedent's Name (First, Middle, La William Rob	ert Wi	lliams			2. Data of Death Month November	Day Year 8, 1999	5:40 PM
Examiner	4a Facility Nama (If not Institution, giv	e street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of Dea	ath
	Salisbury Cente		derCare		Salisbury	, MD	Wicomic	0
Funeral Director	221-03-0390	7. Aga (In yr.	s. last birthday) Yrs.	ff Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9-15-19	Year) 9. Bit	rthplace (Stata or Foraign ountry) Md.
show show id.at	Usual Rasidance of Decedant 10a. Stata 10b. County		City, Town or Lo	cation			-17	10d. Inside City Limits
oct mile v	De. Susse	X	Laurel	T				
uth with the Ma 23s or 28s-1 s unt be notified	10e. Street and Number 128 Lakeside Dri	ve		10f. Zip Coda	56	10	g. Citizen of What C USA	ountry?
1020 Durs after death with the Maryla raf, or thems 23s or 21ser show Examiner must be notified at 1 by Funeral Director		12. Was Decedent Evar in Armed Forcas? 1 Yes 2 No If Yas, Giva WWI Year or Dates:	U,S. 13. 1	Was Dacedent of I f Yas, specify Cub 1 ☐ Yas 2X No	Hispanic Origin? (Spe an, Mexican, Puarto Specify:	ecify Yes or No- Rican, atc.)	14. Race - Am Black, Whi Specify: W	te, atc.
Maryland Z1Z15-00Z0 5 should be liled within 72 hours after h and Mental Hygiene. The marked other than "natural", or h traumatic event, the Medical Examin To Be Completed by Fu	15. Decedant's Ec (Specify only highast gra Elemantary/Secondary (0-12)	ducation ide complated) Collega (1-4or 5+)	(Give		during most of worki	ing	Thours	Andustry
C Report	17. Father's Nama (First, Middla, Last)	,	Insur	ance age	18. Mother's Nama		Insurance	
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Ma S 2 S S S S S S S S S S S S S S S S S S	19a. Informant's Name/Ralationship (**	11.00		and Number or Rura			Zip Code)
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DBILLIMOTE, semit. Pages 1 s Department of Hea moortant: if them ny injury or oths	1 Description 3 Description 3 Description 3 Description 5 Description 5 Description 5 Description 3 Description 5	Ramoval from State	cematary, crar	natory or other pla ill Ceme		1-11-99	Laurel, 1	
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Physician /Medical Examiner	Immediate Ceusa (Final diseasa or condition resulting in death)	a. PNEUN Due to Due to	(or as a conseq	juance of):	CIN'S	1 ~ Re	2115	
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d by the defected Physic	Part II. Other algorificant conditions of	ontributing to death but not re	esulting in the u	ndarlying causa gi	ven in Part I.			to the cause of death? Probably 4 Unknown
The law requires that the death certificate has been signed by the attending page 2 should be detached for use a Completed by Physiclan/Mi	CA136 10	11/99				24a. Was ar perform		Were autopsy findings available prior to completion of cause of death?
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vital nec	25. Was case referred to medical				26. Place of Death			10 165 20 110
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Nor Attending Fater death. I Director: After d in by the funer ertification:	3 Suicide 6 Could not be datarmined	28a. Placa of Injury - At building, etc. (Spec	homa, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number or f , Stata)	Rural Routa Number,
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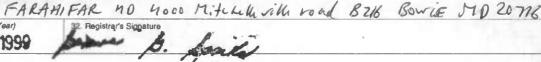
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Lest) 2. Date of Death Morth Dey 1, **Physician** T. MCJOHNNIE YOUMANS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, AUDUST 3, 5. Social Security Number Sex 1X M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 59 Yrs. 069-32-0364 Director South Carolina Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Director Prince George's Landover Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20785 6222 Otis Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Maintenance Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be Mental Adeline Keraes Johnnie Youmans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 735 Lincoln Avenue, Brooklyn, New York, 11208 Sylvia Youmans/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Buriel 2 ★ Cremation 3 ☐ Removal from State 11/06 20c. Location - City or Town, State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1999 Belstville, Maryland 21. Signature of Funeral Service Licenses J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 Na 23a. Part1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Zday Examiner Due to (or as a consequence of): Examiner primina Dilatua The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. aren Physician/Medical Due to (or as a consequence of): 100001 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. g 24b. Were sutopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes an autopsy 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Neturel 5 Pending s after death. 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Towh, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Roitan Funkton 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State NOV 0 8 1999 Registrar

ROINTAN



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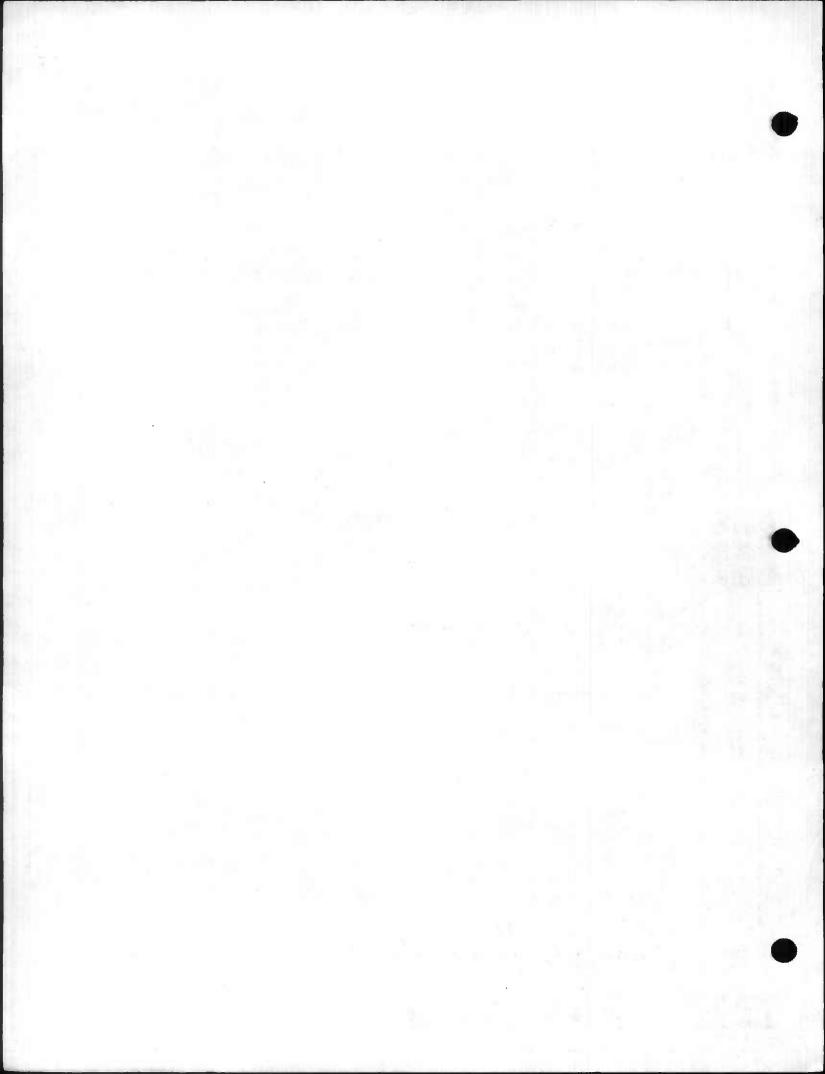
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State of Maryland / Department of Health and Mental Hygiene

† Physician	Decedent's Name (First, Middla,	Last)		Certifica	te of	Death	2. Date of Dea Month	th Day	Year	7565 3. Time of Death
/Medical	Moon Doon Yee	900000000000000000000000000000000000000				4h City Town or	Novembe			2:35 am
Examiner	4a Facility Name (If not institution,	Tive street and number)					Location of Death	4c. County		
	Holy Cross Hosp: 5. Social Security Number		// t t	Willed	r 1 Year	Silver S	Spring	Montg		
Funeral Director	577-62-1494 Usual Residence of Decedent	1 X M 2 □ F	77 Y	rs. Months		Hours Mir		Year) 1922	9. Birthpi Count China	aca (State or Foreign ry)
show stat	10a. State 10b. County		10c. City, Town						10	od. Inside City Limits
or 28a-f a be notified Director	Maryland Montgor	nery	Rockvil							
tor death with the Maryland thems 23e or 28e-f show ther must be notified at funeral Director	10e. Street and Number 4701 Lance Court			208	Code 53			0g. Citizen of V USA	/hat Count	ry?
ar, or its	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Detes:				lispanic Origin? (an, Maxican, Pua Specify:	Specify Yas or No- rto Rican, etc.)	Blac	e - America k, White, e	itc.
ed within 72 hours ygiere. wr than "natural", f, the Medical Eas Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	+)	tife. DO NOT	al Occup ork done	eation during most of wi d)	orking	16b. Kind of Bu		Food
Hygies Hygies Hygies Mr. The	12		Che	f				Restaur		Service
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Menta Menta affe er To E	Moon Hung Yee					Kam Chir	n			
2 sho and la is ma	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	s (Street	and Number or F	Rurat Route Numbe	r, City or Town,	State, Zip	Code)
CENE	Lau Unk Yee/ Wit	е	47	01 Land	e Co	urt, Roc	ckville,	MD 208	53	
Pages 1 and nent of Health ret; If Item 27 iny or other to	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		cemetery	Disposition (Na crematory or olitan	other plac		Nov 19 1999	20c. Location -		
permit. Pages 1 at Department of Hea Important: if tem any injury or othe atics.	21. Signatura of Funaral Service Lie	censee					Funeral	Home,	Inc.	MD 20901
Physician	23a. Part. Enter the diseasa, or conshock or heart failure. List or	implications that caused by one cause on each lin	tha death Do no	1					,	Approximate Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Fever ar	nd Pulmo			rates	0-11/0			EV 30
entificate be associted fing physician and se as the bunal-transit	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	с	Nefrac Oue to (or as a co	onsequence of		c Lympho	ocytic Le	ukemia		
at the death certification of the etherding etached for use etached for each etached fo										
0 0 2 -	Part II. Other afgniffcant conditions	contributing to death bu	t not resulting in	the underlying	cause giv	en in Part I.	23b. Did to	obacco use co	tribute to	the cause of death?
requires that the de been signed by the should be detached leted by Physic							101	ea 2000	3 Prob	ebly 4 ☐ Unknown
5 S S							24a. Was a perfor	an autopsy med?	ava	re autopsy findings illable prior to apletion of cause leath?
The le							1 🗆 Y	es 2 No	1□	Yes 2□ No
certificate rector, pag	25. Was case referred to medical					26. Placa of De	eath (Check only or	ne)		
Physician: this certific ral director,	examiner? 1 Yes 2 No	Hospital: 1 1 Inpatier	nt 2 ER/Out	patient 3 D	OA Oth	ner: 4 Nursing	Home 5 Resid	ence 6 Oth	er (Specify)
P Per C	27. Manner of Death 1 \(\overline{\text{Z}} \) Natural 5 \(\overline{\text{Pending}} \) ending 2 \(\overline{\text{Accident}} \) Accident	28a. Date of Injury (Month, Day)			28c. fnjur Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occur	ed	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could no 4 Homicida determin		ry - At homa, fan (Specify)	m, street, facto	y, offica		28f. Location (S City or Tow		er or Rurai	Route Number,
he Hoepital or in 24 hours afte he Funeral Diri pletely filled in edical Cert	29a. Certifier (Check only one) 12 Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examination and	death occurred for investigation	at the tin	me, date and place pinion, death occ	ce, and due to the courred at the time, o	ause(s) and ma late and placa,	nner as stand due to	ated. the cause(s)
within 7 to the comple	29b. Signatura and titla of certifiar	A 11	177.53	21	c Licens	e number	2	29d. Date signe	d (Month, L	Day, Year)
	Marke	1 He	desi	4 h	D	D 37236	5	Novembe	r 13.	1999
10	30. Name and address of Jerson who Carolyn B. Hendi			Type, Print) / Ockleds	e DR		Bethesda			
State	31. Date filed (Month, Day, Year)		r's Signature	!	,	,	Jesinebud	,		

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. #10c, 11/24/99, BMW, Montg. Co. State of Maryland / Department of Health and Mental Hygiene 9 9 #10e, 19b, 11/24/99, BMW, Co. Certificate of Death Amend Amend 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death November 11, 1999 **Physician** Jean Zalevsky 7:30 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Takoma Park Washington Adventist Hospital Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | September Year)12, 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□F Months 102-10-5014 84 Yrs. Director Pennsylvania Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show Silver Siver Spring 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery 10e. Street and Number

1702 Lowander Lane 10f. Zip Code 10g. Citizen of What Country? 20901 United States d 2 should be filed within 72 hours after death it and Montal Hygiene.
7 Is marked other than "natural", or items 23, traumatic event, fire Medical Entities must Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indien 11. Maritel Status Black, White, efc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 9 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Civil Servant Federal Government 18. Mother's Neme (First, Middle, Malden Sumame) 17. Fether's Neme (First, Middle, Lest) Pages 1 and 2 should be filt ment of Health and Mental Hi ant II from 27 is marked oth lary or other traumatic even Rose Simon Morris Petrokovsky 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1702 Lowander Lane Silver Spring, MD 20901 702 Sidney Zalevsky / Husband 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 19698 permit. Pages Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Mt Lebanon Cemetery Adelphi, MD 4 Donetion - 6 ☐ Other (Specify) 22. Name and Address of Facility Stein Hebrew Memorial Funeral 21. Signature of Funeral Service Licenses 232 Carroll St. NW Washington, DC 20012 sase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated ovents resulting in death) Last Due to (or as a consequence of): pug physician a s the burial-Division of Vital Records, P.O. Box 68760, that the death certificate be Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the detached signed by t 3 Probably 4 ☐ Unknown 1 Yes P 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? N.D **Dage 2** AL. certificate 25. Was case referred to medical examiner? 86 26. Place of Death (Check only one) 27. Manner of Death Other: 4□ Nursing Home 5□ Residence 6□Other (Specify) Certification: To 1) Inpatient 2□ ER/Outpatient 3□ DOA 100 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Affer Attending. 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation i or Attend after death Director. 3 Suicide 5 ☐ Could not be Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital or within 24 hours at To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D42403 11/12/99 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
RAJ MATHUR LOG IRVING STREET, NW, WASHINGTON PC 20010 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State 1999 Registrar

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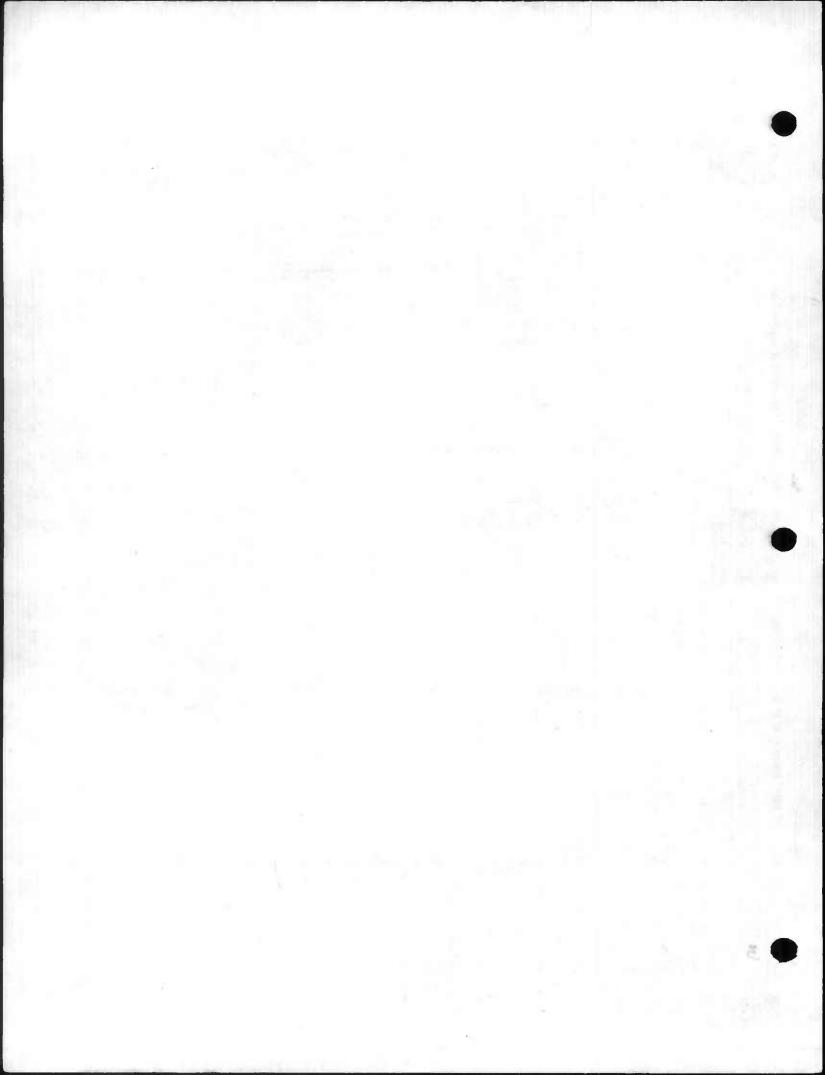
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Emma Rieman Waters Ziehnert November 10, 1999 10:45 PM /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Potomac Valley Nursing Home Montgomery Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2점F 712-14-8868 90 Yrs. June 26, 1909 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show notified at 1 ☐ Yes 2 No Directo Fairfax Virginia Falls Church 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rams 23s or must be 7759 Inversham Drive #244 22042 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. atter 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☐ Married ð altimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: hours a ğ 3 ₩ Widowed 4 Divorced White Year or Dates: natural. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Pages 1 and 2 should be next of Health and Mental int: If less 27 is marked or Henry Rieman Ida Matilda Child 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Department of Health Important: If Item 27 I Tiffany Birch/Daughter 7759 Inversham Drive #244, Falls Church, VA 22042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Nov. 14, 1 ☐ Buriat 2 ☑ Cremation 3 ☐ Removal from Stete Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1999 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805
enter the mode of dying, such as cardiac or respiratory arrest.

Approximate 21. Signature of Funeral Service Licensee M00198 Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finat Aspiration Pneumonia disease or condition resulting in death) hours Examiner Due to (or as a consequence of): Examiner Alzheimer's Dementia years be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 80 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 0 signed b Records. by been si 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 s 1 Yes 2₺ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ◯ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Attending 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral process. 1 TYes 2 TNo Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 11, 1999 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Suhair H. Abulfarag, M.D. 481 North Frederick Avenue, Gaithersburg, Maryland 20879 32. Régistrar's Signature State

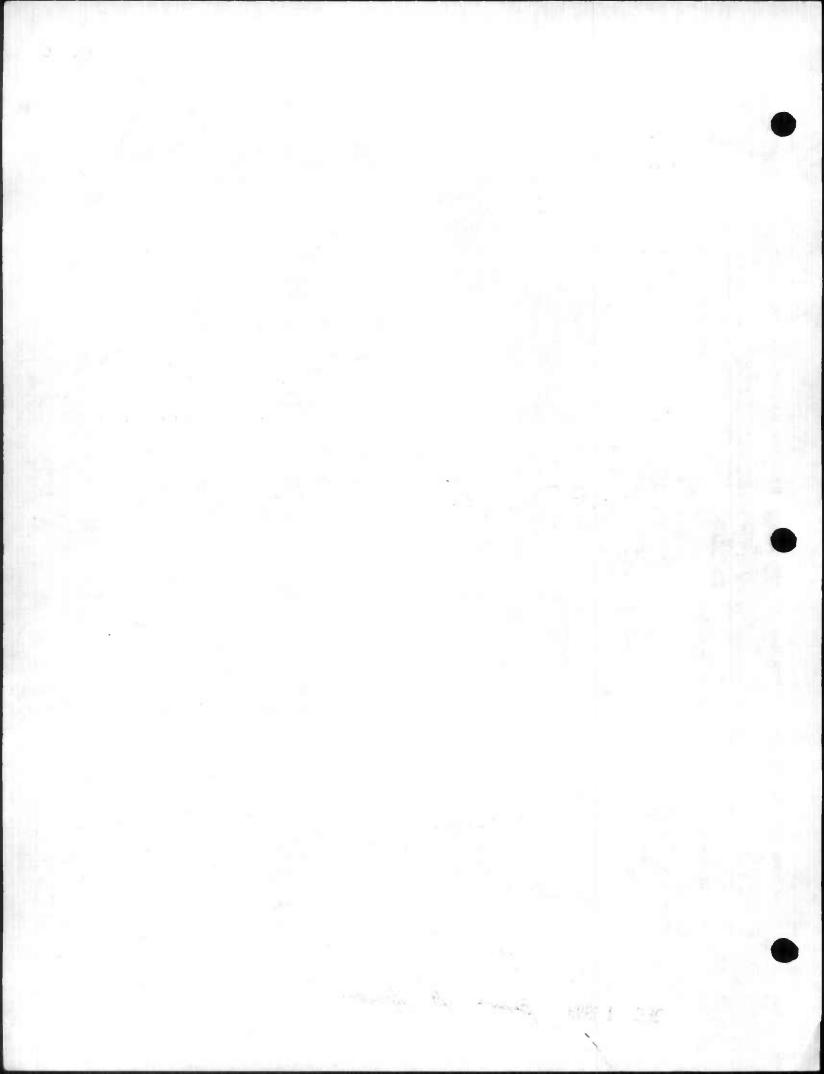
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ral or	213	al Security N 3–80–6	896	6. Sex 1 □ N	A SERF	7. Age (In yrs. 34	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day August 2			place (State or Form ntry) ryland
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Cat	3 □	Accident Suicide Homicide	6 Could	d not be mined	28e. Plece	of Injury - At hing, etc. (Specif		M reet, facto		Yes 2121	No	28f. Location (S City or Town	treet and Num	ber or Run	al Route Number.
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Medical Certification		gneture and	title of certifi	4	74	/			O	.C.M.	≦.		NOVEME	BER 27	7, 1999



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Day Physician Month Edna Madeline Adams November 27 1999 9:30PN /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Hospital Center 7. Age (th yrs. last birthday) If Under Baltimore Franklin Square If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 213-09-2918 1 M 2 TF 81 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits triban "natural", or frame 23s or 28s-f show the Medical Experient rount be notified at Director Baltimore Dunda1k 1 Yes 2€No Maryland 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or Items 23s or 21222 United States 1749 Portship Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: White P 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Department of Health and Schould be filed Department of Health and Mental Hygic Important: If item 27 is marked other tanness. 12 Years Tin Sorter Steel Industry altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Russell Merritt Anna Phisterer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen S. Adams (Daughter) 2721 Coldstream Way Apt. C Parkville, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donelion 5 Other (Specify) Entombment Sacred Ht. of Jesus Cent 12/1/1999 Dundalk, Maryland 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Topic Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Few MONTHS Examiner Examiner physician and tha burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 Physician/Medical FAILURE P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, à 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funaral director, i 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Menner of Death 28a. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) DR. BAITIMORE, MARYLAND 21237 Veung 9000 FRANKlin Square DR KAMIUN 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State

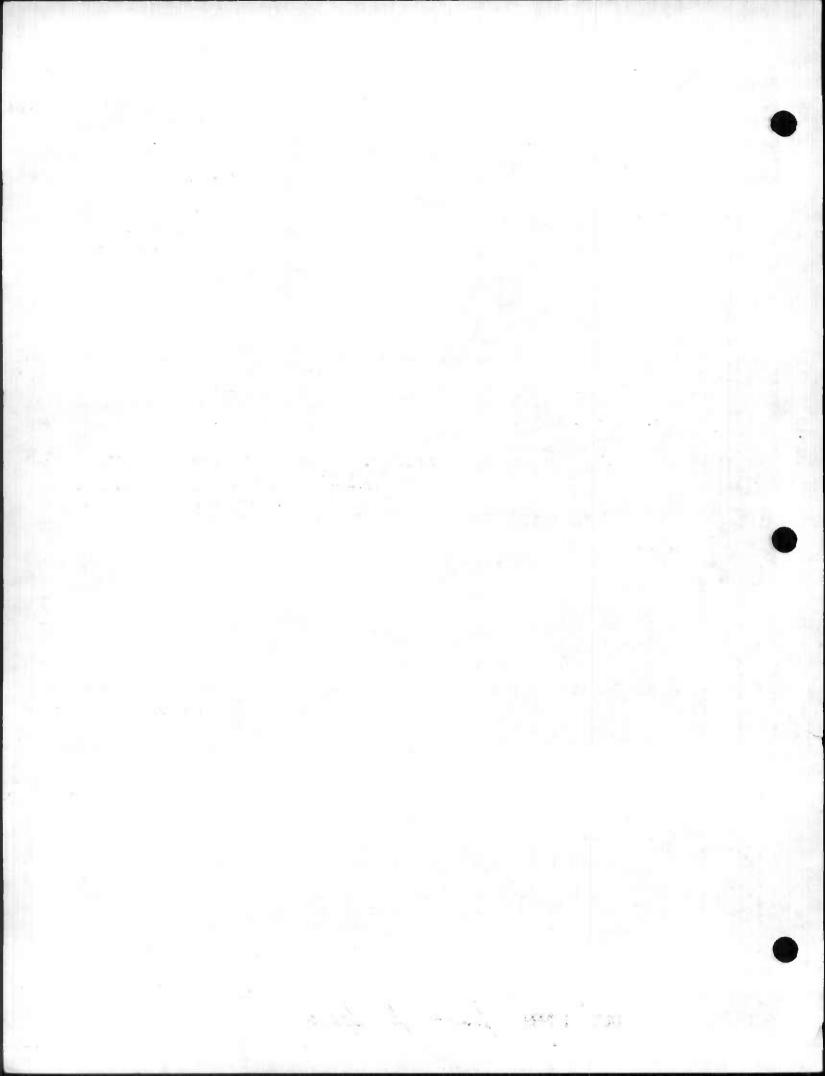
DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental HygieneQ Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Dolores Jean Ashton 4:08 AMI 26 1999 November /Medical 4b. City. Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner FRANK I'N SEUARE
5. Social Security Number 6. Seu BAITIMORE Hospilal Cen ose dAle If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 KF Vrs 212-34-4847 62 Director March 2,1937 West Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow t∏Yes 2FINo Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 8337 Bletzer Road Rems 23s 21222 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 ta marked other than "natural", or ite 1 Never Married 2 Merried 1 Yes 2 No
If Yes, Give
Yeer or Detes: Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 Years Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Arthur Talkington Nelma Viola Bunch 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health a Important: If Item 27 la eny Injury or other trae (Husband) Mr. Edward W. Ashton 8337 Bletzer Road Dundalk, Maryland 21222 altimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Gardens of Faith Cemetery 11/30/99 Rosedale, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician tmmediete Cause (Finel diseese or condition resulting in death) /Medical Matastatic Larcinoma of Right Breast Years Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): 68760 Physician/Medicai Due to (or as a consequence of): Box (P.O. | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by a 10 Yes 2 No 3 Probably 4 Unknown Records. ğ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yes 1 Yes 2 No 2 No Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: After Division Hospital or Attending 5 Pending Investigation 1 Neturel s after dea... 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled edicai 29a. Certifier ŝ 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 2 November 26, 1999 RD 187161

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State Registrar SENARE DR. BAITIMORE, MARYLAND 21237

30. Neme and address of person who completed coule of death (Item 23a) (Type, Print)

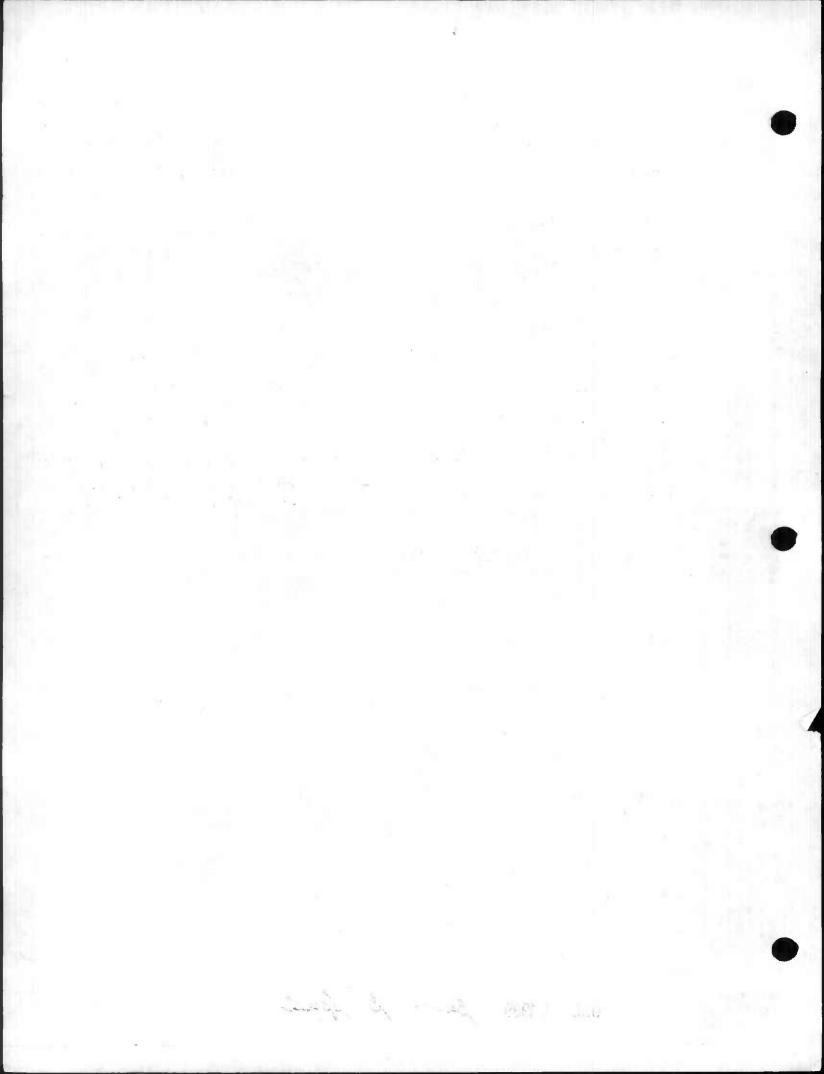
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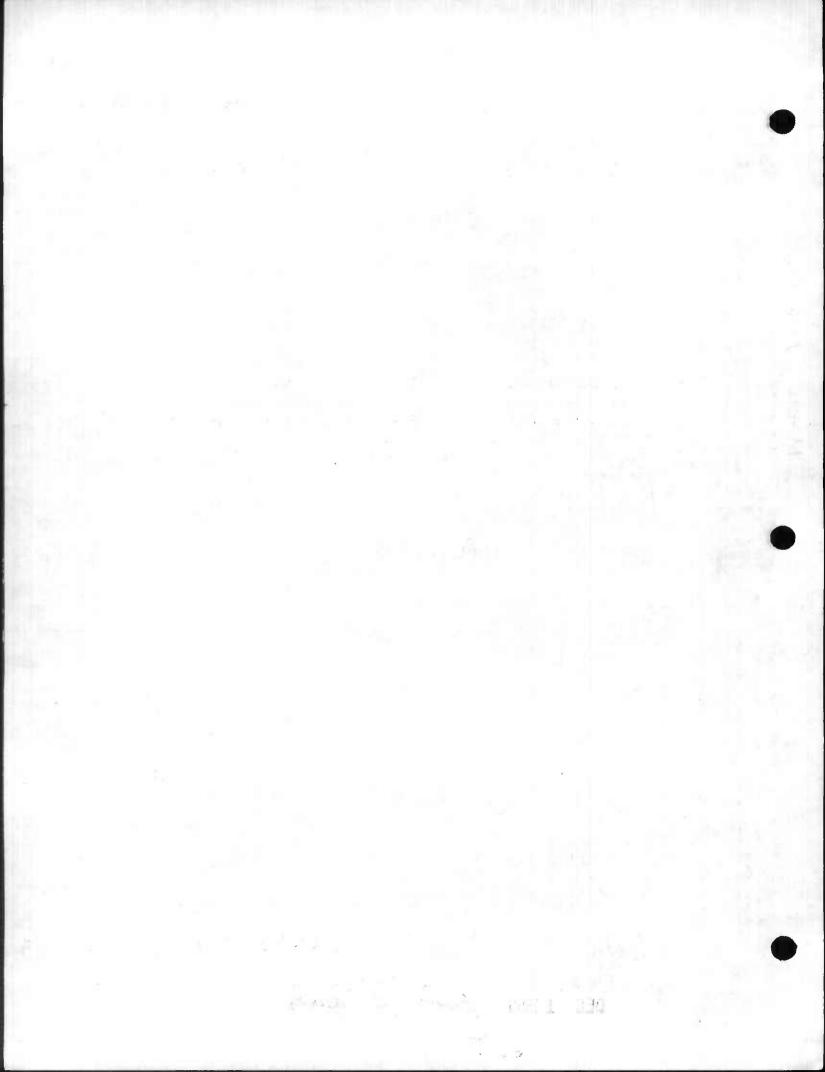
31. Dete filed (Month, Dev Year)



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-	MD	Anne Ar	runde1	An	napolis	5				1 Yes 2
	10e. Street and N 506 Pa:	fel Road				10/. Zip Code 214			10g. Citizen of USA	Whal Country?
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	21. Signeture of I	Funeral Service Licer	S Dx	H	1	Hardest	dress of Facility Ly Funera gely Aven			Md 21401
Ì	23a. Pert1. Enler shock, or he	r the disease, or own eert failure. List only	plications thet cause one ceuse on each I	d the deeth	n. Do not enter	the mode of	tying, such es card	iac or respiretory	errest,	Approximete Interval Between
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DHMH 16 Rev 6/95



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. AMEND ITEMS: #5, 17,18 PER F.H. G180 2-9-2000 We Department of Health and Mental Hygiene 37572 AMENDED ITEM #28f PER ME G778 12/1/99 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RICHARD J. BELL Month 11 **Physician** 04:13 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HUNT VALLEY BALTIMORE I - 83 +Quaker Bottom Road | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | Feb. 9, 1968 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F 31 Maryland Director Usual Residence of Decedent 10a. State r 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director PA York New Freedom 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ra 23a or 17349 37 Washington St. U.S.A. Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 N No
If Yes, Give
Year or Dates: Nema ? 14. Reca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Bleck, White, etc. ofter 1 ☐ Never Married 2 ☐ Merried 21215-0020 ò White 1 Yes 2 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ges 1 end 2 should be filed within it of Health end Mentel Hygiene. If item 27 is marked other than ", Elementary/Secondary (0-12) 12 College (1-4or 5+) Rental Trucking Manager aitimore, Maryland 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumame) CAROLUS BELL SR. Maryana Ebelke MARYANNA EBELKE Carlos Bell, Sr. 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 37 Washington St., New Freedom, PA 17349 Charlene L. Bell/Wife 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Nov. 27, 20c. Location - City or Town, Stete Peges 1 ☑ Burial 2 ☐ Cremetion 3 ☑ Removel from State permit. Pege Department of Important: If eny Injury or page. New Freedom Cemetery 4 Donation 5 Other (Specify)

21. Signature of Furieral Service Ligensee New Freedom, PA 22. Name end Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA arlenstern 17349 23a. Part I Shar his disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel TRAUMA 1 SECOND MULTIPLE disease or condition resulting in death) Examine Examiner ACCIDENT MOTORVEHICLE s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, that the death certificate be an/Medical Due to (or as a consequence of) 000 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2XNo 3 Probably 4 Unknown bengis Records. à 24b. Were autopsy lindings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No Division of Vitai 8 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After thi funeral Date of Injury
(Month, Day Year)
21-1999
04:13 9 M 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Attending 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours effect death. To the Funeral Director: Afte completely filled in by the func MOTORVEHICLE ACCIDENT 1 Yes 2 No 2 KAccident 281. Location (Street and Number or Rural Route Number, City or Town, State) DUAKER, BOTTOM ROAD RURAL TO STORY OF TOWN ROAD RURAL TO STORY RURAL RURA 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide HIGHWAY 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. Medical 2DMedical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and memor stated. 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-38363 11-22-1999 ranolseo zono MD and address of person who comp se of death (Item 23a) (Type, Print) 4RASSO 6569 N. CHARLES ST. TOWSON FRANCES MD 32. Registrar's Signature State sporker Registrar **DHMH 16 Rev 6/95**

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State of Maryland / Department of Health and Mental Hygiene QQ

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/Medical Examiner	4a Facility Neme (If not instit						4b. City, Town, or	Location of Deat	h 4c. County			
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Funeral Director	5. Social Security Number 217 · 40 · 3138 Usuel Residence of Deceden		7. Ag	e (In yrs. 56	last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min		rth sy, Year) 43	9. Birth	olace (State or I	Foreign
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	101	-	La La			Du	3725		11/30	199		
2/9	30. Nama and eddress of per	son who com	pleted cause of d	eath (Item	23a) (Type, F	Print)						
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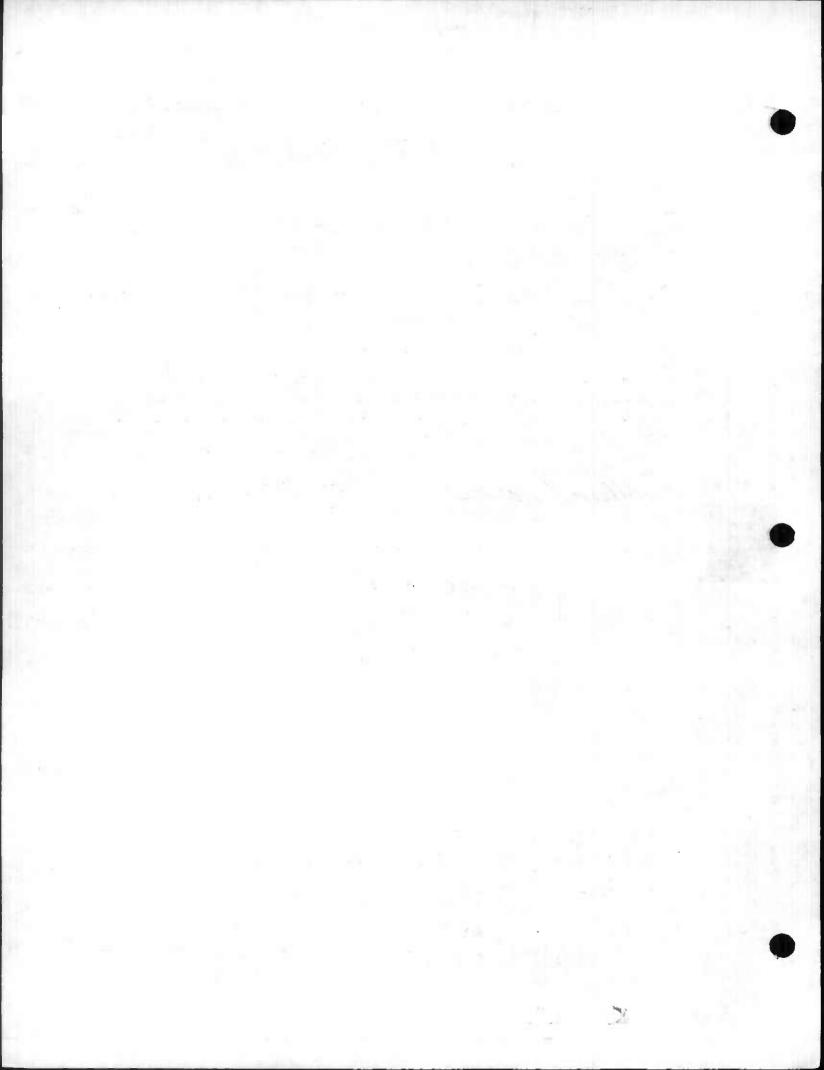
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Brooks :12AM NOVEMBER 23 Caner /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Pi HAL HUnder 1 Year I timore Johns 60 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, 06/17/ If Under 24 Hrs 9. Birthplace (Stete or Foreign **Funeral** Months 1 M 2 F MASSACHUSETTE Vre 22 Director 017-58-6458 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23s or 28s-f show the Medical Example: must be notified at 1 SYes 2 □ No Director MD N/A BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1-B HAMILL RD. 21210 USA death v Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2₽No Specify: Specify: à WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other that any injury or other traumatic event, that other. EDUCATION 4YRS STUDENT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be JOHN H. BROOKS KINGSLEY BARRETT 19e. Informent's Name/Reletionship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KINGSLEY B. BROOKS (MOTHER) 1-B HAMILL RD. BALTO., MD. 21210. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) DRUID RIDGE CEMETERY11/26/99 PIKESVILLE, MD. 21. Signeture of Funerel Service Licensee 22 Name and Address of Facility HENRY W. JENKINS & SONS CO. elleas 4905 YORK RD. BALTO., MD. 21212. Approximete Intervel Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in death) Examiner Due to (or es a consequence of) Examiner malforme physician and the burial-transit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as e consequence of): Box 68760, herniation Physician/Medical Due to (or es a consequence of): The law requires that the death certificate Brain stem Failure P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed i of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? should I 24e. Wes an autopsy performed? Completed page 2 s 1 Yes 22 No 1□ Yes 2 DNO Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Certification: To 1□ Yes 2☑ No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending investigation Injury To the Nospital or Attendin within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 Yes 2 No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Welstoer LM November Physician 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) N. Wolfe Baltimure

State Registrar 31. Dete filed (Month, Dey, Year)

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32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Day Yaar Marie P. Beresh 29 1999 NOVEMBER. /Medical 8:55 AM 4e. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore H Under 1 Yaar If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. Jan. 1907 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthpleca (Steta or Foreign Country) **Funeral** 1□ M 21XF Yrs. Director 215-09-7535 92 Maryland Usuel Residence of Decedeni 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rithan "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Timonium 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 2300 Dulaney Valley Road #C111 21093 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yas, Give Yaer or Detes: 14. Rece - Amarican Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 Never Merried 2 Married 1 ☐ Yas 2X No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Social Security Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. Administration Clerk marked other traumetic event, Maryland I Heeith and Mental Hy 17. Fether's Nama (First, Middle, Last) 18. Mothar's Neme (First, Middle, Melden Surneme) Be Michael Beresh Pages 1 and 2 should Julia Budacz 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. John M. Stewart / Nephew 33 Montvieu Court Hunt Valley, MD 21030 other 1 altimore, 20b. Pleca of Disposition (Nema of cematary, cramatory or other piece) 20e. Method of Disposition Deta 20c. Location - City or Town, Steta 0 1 XBuriel 2 ☐ Crametion 3 ☐ Ramoval from Siete = b permit. Page Department of Important: If eny injury or once. Holy Rosary Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 12/3/99 Baltimore, Maryland 21. Signeture of Functal Service Licansee Timothy S. Harman .eonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical 4 HOURS RUPTURED ABDOMINAL AORTIC ANEURYSYM **Examiner** Due to (or es a consequence ot) The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to Immadiata causa. Enter Underlying Cause (Diseese or Injury the Initieted events rasulting In deeth) Last pue buriel-tran Due to (or es a consequence of): P.O. Box 68760, attending physician for use es the buria Physician/Medical Due to (or es a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ page 2 should Completed 24a. Wes an eutopsy performed? 24b. Were autopsy tindings availeble prior to peed completion of cause of death? certificate 1 Yes 2 No 1 ☐ Yes 2 No Attending Physician: 8 25. Was case reterred to medical 28. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Suppatient .cours effer death.
.eat Director: Affer b.
.e. by the funeral dir ٩ 1 ☐ Yes 2 ₺ No 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Manner of Deeth Deta of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending Invastigetion 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Sulcide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 I Homicide Hospital To the Hospital within 24 hours or To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) atividad D. de Lean; m. D. 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) NATIVIDAD D. OSLER DRIVE, TOWSON, MARYLAND 21204 DELEON, M.D., 7601 31. Dete tiled (Month, Dey, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

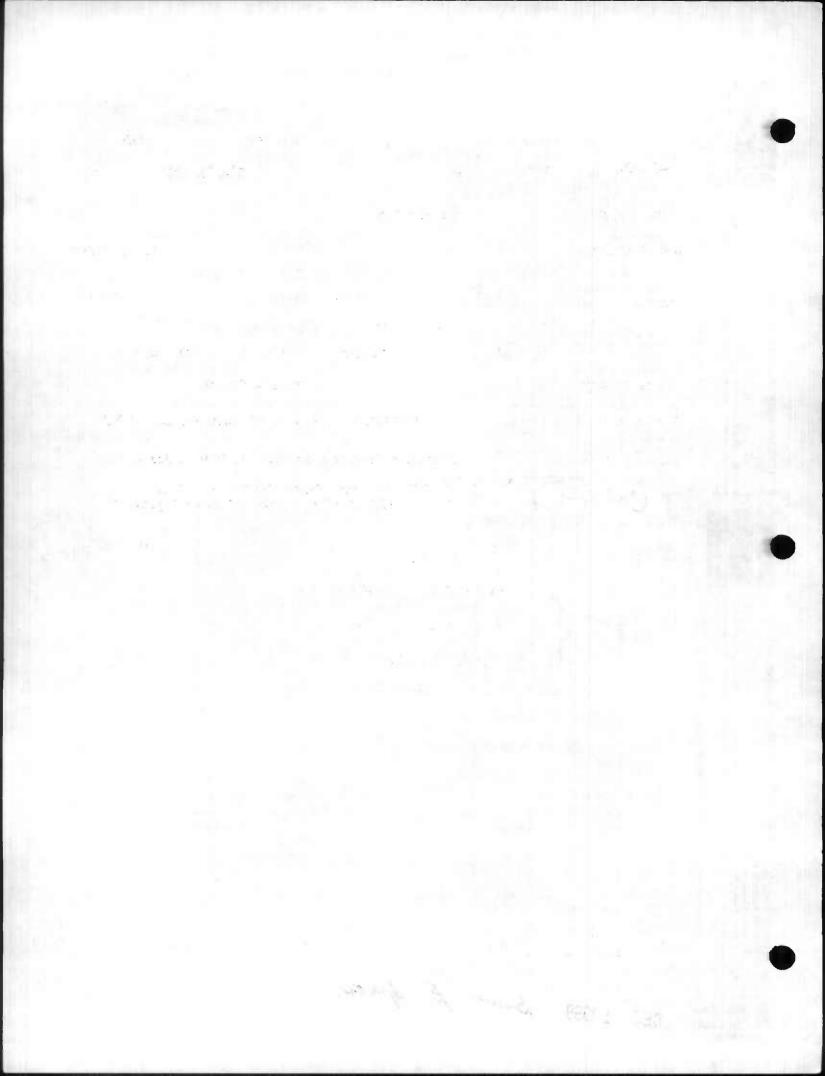
Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 3. Tima of Death 2. Date of Death Month **Physician** CUMMINGS GEORGE 1999 NOVEMBER 7:10 PM 29 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL CENTER N/A If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 219-36-7091 16€M 2□ F Months Days Yrs. 59 Director June 29, 1940 MD Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show worle MD N/A Baltimore City MXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or Items 23s or the Medical Examiner must be r death with 4100 West Bay Court 21225 United States Funeral 11. Marifal Stafus 12. Was Decedenf Evar In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, Whifa, efc. Pages 1 end 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yas, Give Year or Dates: 1 ☐ Never Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 200 No Specify: Specify: White py XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) NA Elementary/Secondary (0-12) Construction Construction 7 is marked other traumatic event, 18 Mother's Name (First Middle Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) Be Jerone Cumnings Certrude Parrish 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a: If item 27 is Charles A. Cummings / Brother 1922 Wilmington Avenue, Baltimore Maryland 21230 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Green Mount Crematory, December 1, 1999 Baltimore City 21. Signafura of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens FUNERAL Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that call sad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the ach line. Approximate Interval Between Onsat and Death **Physician** PNEUMONIA /Medical Immediate Cause (Finat disease or condition resulting in death) 7 DAYS **Examiner** Due to (or as a consequence of): Examiner CANCER GASTRIC sician and bunel-trensit that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that hitlated events resulting in death) Lasf Due to (or as a consequence of): physician s the buriel -ARYNGEAL CA Division of Vital Records, P.O. Box 68760 Physician/Medical as HYPERCALCEMIA ettending esn 0 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of ceuse of death? pege 2 hes 1□ Yes 2☑No 1 ☐ Yes 2 ☐ No certificete Hospital or Attending Physicien: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 27. Manner of Death 28a. Date of tnjury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending s efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edicai 29b. Signature and tifle of certifier 29d. Data signed (Month, Day, Year) 29c. License number timpomds: (MD.) RES 000 NOVEMBER 29, 1999 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) TSHERING DORSEE AMDO, HARBOR HOSPITAL GENTER BOOI SOUTH HANOVER STREET, BALTIMORE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 1999

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Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 9 3 7 5 7 7

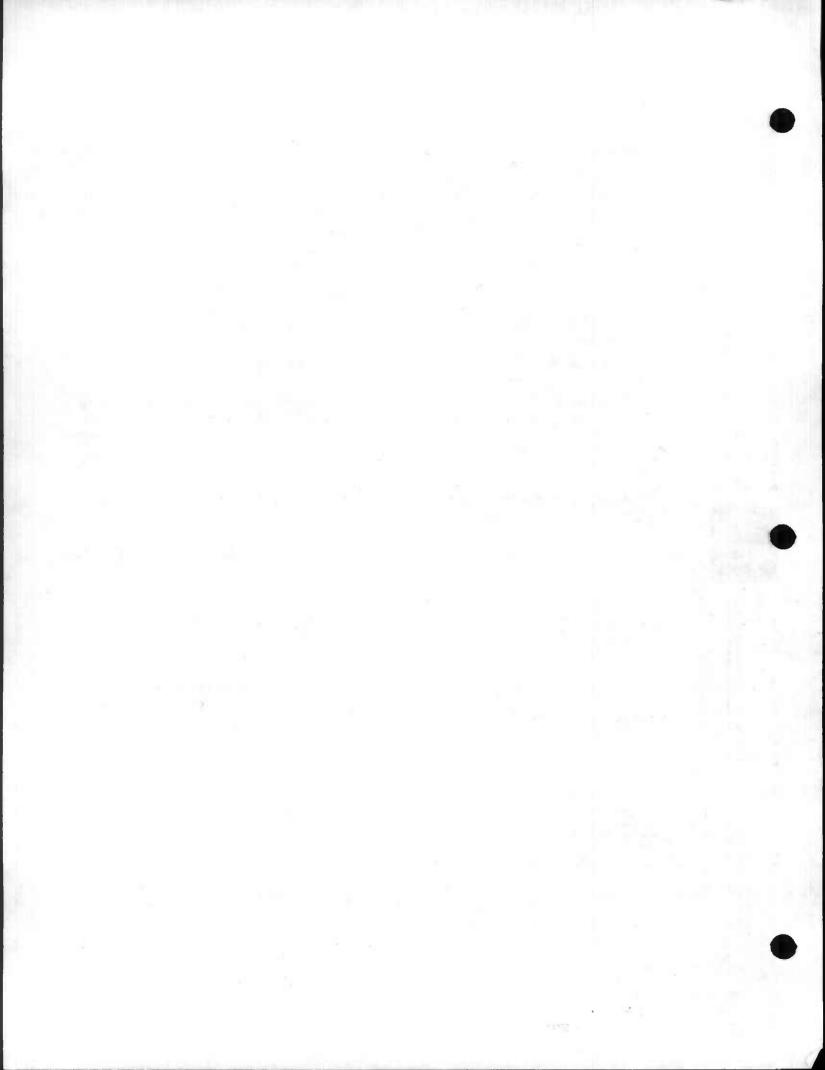
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State of Maryland / Department of Health and Mental Hygiene QQ

					Cel	tificate	OT L	Jeath		Reg. No.		
Physici	an	Decedent's Neme (First, Middle, La							2. Date of De	ER ^{Da} 27,	4 Y995 C	3. Time of Deeth
/Medic		Leora E.	Colbert									12:45 PM
Examin	er 	4a. Facility Name (If not institution, given Saint Joseph	Medical	Cente	r		46	o. City, Town, or t	ocation of Deat	h 4c. County	Balt	imore
Funeral Director		2.2 00 0302	DM 2DE	ge (In yrs. last 35	birthdey) Yrs.	If Under 1 \ Months D	Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De Nov. 1	th v. Year) 1, 1914	9. Birthp Court Penn	iace (Stete or Foreign try) sylvania
and wa		Usuei Residence of Decedent 10a. Stete 10b. County		10c. City, To	wn or Lo	cation					1	Od. Inside City Limits
tha Marylar 28a-f show	or	Maryland Baltime	ore	Tow								1 ☐ Yes 2 ₽ No
tha 28s	Funeral Director	10e. Street and Number	51.6	100	5011	10f. Zip Co	ode			10g. Citizen of	What Cour	Λ
3a or		1306 B Denby Road	3				286			U.SA		ary.
death	nera	11. Maritel Stetus	12. Was Decedent		13. \			spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No		e - Americ	an Indien,
permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Insportant: if Item 27 is marked other than "netures", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a once.	by	1 ☐ Never Married 2 ☐ Married 3 Æ Widowed 4 ☐ Divorced	Armed Forces' 1 Yes 2X If Yes, Give Yeer or Dates:			Yes, apecity ☐ Yes 2大		Specify:	Rican, etc.)	Specif	ck, White, y: Wh	etc. ite
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16	Sa. Deced	ent's Usuai C	Occupat	tion	kina	16b. Kind of B	ualness/inc	Justry
ithin an	nple	Elementary/Secondary (0-12)	Coilege (1-4or	5+)	life. L	O NOT use r	retired)	uring most of worl	Ciriy			
filed within Hygiena.	S	12			Home	Maker				Own 1		
d 2 should be file th and Mental Hy 7 is marked oth traumatic event	Be	17. Fether's Neme (First, Middle, Last)						18. Mother'a Nam	A		ne)	
should be ind Mentai i marked of umatic eve	10	Clark E. Wisor							Elda B	4		
12 sho h and r is me rraume		19a. Informant's Name/Reletionship (nd Number or Ru				
1 and 1 Health em 27 inther tra		Mr. Louis F. Frie	dman/Attoi	-				Ave. Su				
bermit. Pagas 1 ar Department of Hee mportant: if Item in injury or othe		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		ceme	tery, cren	sition (Neme natory or othe	er plece		Dete	20c. Location -	City or To	wn, State
t. Partant		4 □ Donation 5 ☑ Other (Specification)		nt Dula					2/1/99	Timoni	um, M	aryland
pemit. Page Department of important: If any injury or ance.		21. Signeture of Funeral Service Licer	isee	1	22	. Name and A	Address	s of Fecility		10	50 Yo	rk Road
20200		Wallace.	S-Broo	By Dy							wson,	Md.21204
Physician /Medical Examiner		23e. Part1. Enter the disease, or com ahook, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)	SUBARA	ACHNOI	D HE	MORRI			or respiratory e	rrest,	-	Approximate triterval Between Onset end Death 4 HOURS
	Jer			Due to (or as	a conseq	uence or):					1	
icata be axecuted physician and s the burial-transit	I Examiner	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or as	a conseq	uence of):					 	
E 0 6	Physician/Medical	that initiated events resulting In death) Lest	d	Due to (or as	a consequ	uence of);					i	
a death cert the attandin	ysician	Part II. Other significant conditions of		out not resulting	In the ur	derlying caus	se give	n in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
signed by the did be datached	by Ph								10	Yes 2 No	3 Prot	ebly 4 Unknown
aw requ	Completed								24a. Was	en autopsy omed?	ave	ere autopsy findinga allable prior to appletion of cause death?
ysician: The is s certificata he director, paga	E O								10	Yea 2 No	10	Yas 20 No
	Be	25. Was case referred to medical						28. Place of Dee	th (Check only o	one)		
2 00	10	examiner?	Hospitel: 1 Inpati	ent 2 ER/0	Dutpetien	3□ DOA	Other			denca 8 □Oth	er (Specifi	()
or Attending Phatfar daath. Director: After thi		27. Menner of Death 1. Natural 5 Pending 2 ccident investigation	28a. Date of Inju (Month, Da	iry 28b	Time of Injury		Injury Work			how Injury occur		,
or Attending s after death. i Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	286. Place of in	jury - At home, c. (Specify)	farm, stre	et, fectory, of	ffice		28f. Location (City or To	Street and Numb wn, Stete)	er or Rura	l Route Number,
To the Hospital or / within 24 hours aftar To the Funeral Director Completely filled in L	edical	29a. Certifier (Check only one) 12 Certifying Ph. 2 Medical Exam	ysician: To the best liner: On the basis o and menner st	i examination a	ge, death and/or inv	occurred at the	the time my opl	e, date and plece, nion, death occur	and due to the red at the time,	cause(s) and me date and place,	anner as st and due to	ated. the ceuse(a)
To the To the Comp	×	29b. Signature and title of certifler	M.D.				icense 307	number 49		29d. Dete signe		
10		30 Name and address of person who	completed cause of c	death (Item 23s	HELE E	R'DRI	IVE	, TOWS	ON, MD	21204		
Stat	e ar	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	~	9	do	2 / /				

State of Maryland / Department of Health and Mental Hygiene O

			ate of Death	R	eg. No.	1019
	Physician	1. Decedent's Neme (First, Middle, Last)		2. Date of Dear Month	Day 1999	3. Time of Death
	/Medical	4n Familia Mana //6 and institution at a standard and supplied	4b. City, Town, or Lo	NOV.		1:15am
	Examiner			ocation of Death	4c. County of Deet	
		LORIEN-RIVERSIDE NURSING CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unx	BELCAMP ler 1 Year If Under 24 Hrs.	8. Date of Birth	HARFORD	
	Funeral Director	578-54-2928 1 M 2 F 92 Yrs. Month		(Month, Day)	1907 GER	hplaca (Stete or Foreign untry) MANY
	pue *	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location				10d. fnside City Limits
	Maryl med sho					1 ☐ Yes 2 ☑ No
	vith the Mai or 28s-f s be notified Director	10e. Street and Number 10f. 2	Zip Code	1	0g. Citizen of What Co	untry?
	th will		21017		USA	
020	72 hours after deeth with the Maryland natural, or thems 23s or 28s-f show one Examiner must be notified at steed by Funeral Director	3 ■ Widowed 4 Divorced If Yes, Give 1 Yes	zedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Bleck, White Specify: WH	
2-0	n 72 hours natural, notes Ess	15. Decedent's Education 16a. Decedent's U	suel Occupation work done during most of work	ina	16b. Kind of Business/l	Industry
21215-0020	도 일본 중	(Specify only highest grede completed) Elementery(Secondery (0-12) College (1-4or 5+) Give kind of life. DO NOT	use retired)	ing	HEALER O	0
	Hygiene. ther than	12 SALES 17. Father's Name (First, Middle, Last)	18. Mother's Nem	a (First Middle)	HECHT C	0.
	2 2 2 2			SPRZOI		
7	nd Men		oss (Street and Number or Rut			in Code)
W :	475		ASKI HIGHWA		The state of the s	
re,	二五百百	20e. Method of Disposition 20b. Pleas of Disposition (Acametery, cremetory)			20c. Location - City or	
Baltimore,	Pages net of i	1 Burlel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) MD • NATL •	4 .	2/01/99	LAUREL,	MD
=======================================	P Ports		end Address of Fecility	, , -	LAUKEL,	HD.
Ö	ded drie		Y W. JENKIN YORK RD. B			
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mishock, or heart feliure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) Due to (or est consequence of the consequence of the caused the deeth. Do not enter the mishock, or heart feliure. List only one cause of each line.	included		>0	Interval Between Onset end Deeth
	certificate be executed dring physician and use as the burial-transit	Cause (Dissess or Injury that initiated events resulting In death) Last C. Due to (or es a consequence of the consequence of				
Вох	stending for use			1		
0	y the check	Pert II. Other algnificant conditions contributing to could but not resulting in the underlying	g cause given in Pert I.			to the cause of death?
0	5 60	Chyp. c osmiline film	an dell	die	es 2□ No 3□ Pr	robably 4 Unknown
Records,	s been s 2 should Dieted	O	(24a. Wes a perform	med?	Were autopsy findings available prior to completion of cause of death?
œ ;	The lew page 2 page 2			1 Y	es ZINo	1□Yes 20No
	ystcient: The state director, pag	25. Wes case referred to medical	26. Place of Deel	h (Check only on	10)	
) o	2 00 2	examiner? 1 Yes Yes Hospitel: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nersing Ho	ome 5 Reside	ence 6 Other (Spec	cify)
0 2	After the funeral fune	27. Menner of Deeth 28a. Dete of Injury 28b. Time of (Month, Dey Year) Injury	28c. tnjury at Work?	28d. Describe he	ow Injury occurred	
Sio	Attending in death. Ector: After by the fune fileation	2 Accident investigation	1 ☐ Yes 2 ☐ No			
ā	tal or Attending Price at a ster death. al Director: After to de in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, ferm, street, fect building, etc. (Specify)	ory, office	28f. Location (St City or Town	treet end Number or Ru n, State)	ural Route Number,
	To the Hospital or Attending Physician 24 hours after death completely filled in by the funeral Completely filled in by the funeral Medical Certification:	29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, death occurre to the basis of examination end/or investigation one)	od at the time, date end place, on, in my opinion, deeth occur	end due to the cred et the time, d	ause(s) end menner es ate end plece, end due	stated. to the cause(s)
4	within To the compl		9c. License number	2	9d. Dete signed (Monti	h, Day, Year)
	> - 0	h de contract	78229	AL.	er 21	,1499
~	13	30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)	00775	M	cman 20	1171
4	1 7	LINDA PRIEILIC M.D. 101 WHEEL RD.	BELAIR, MD.	21014.		
	State Registrar	31. Date filed (Month, Dey, Year) 32. Registrer's Signeture	raks			



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37580 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey Year NOVEMBER 20, 1999 **Physician** MORTON JULES DAVIDSON 10:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE - GILCHRIST CENTER TOWSON BALTIMORE 6. Sex 1₽ M 2□ F 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 60 Yrs. 217-34-6141 Director SEP.1,1939 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be r 6605 CHIPPEWA DRIVE 21209 U.S.A. Funeral Нете 2 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2X No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Meritel Stetus Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: WHITE Specify: P 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES AUTOMOBILE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fit h and Mental H Be MAURICE DAVIDSON S. MARY LEVY 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Haalth 6603 CHIPPEWA DRIVE - BALTIMORE, MD 21209

Cand Disposition (Name of Date 20c. Location - City or Town, State Hem 27 STACY PASS / FRIEND other Baltimore. 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State = 8 Important: h eny injury o 4 ☐ Donation 5 ☐ Other (Specify) BETH YEHUDA ANSHE KURLAND 11/23/99 BALTIMORE, MD 21. Signature of Funeral Segrega Light-see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause or each line. Approximate Interval Between Onset and Death for the disease, or com-head failure. List only **Physician** Avyugen (Concer /Medical Immediate Cause (Finel **Examiner** Due to (or es a consequence of) Physician/Medical Examiner cartificata be axecuted the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760. Due to (or as e consequence of): USB BS I The law requires that the death Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA DSDICC 27. Manner of Death 1 ANatural 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D edical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner signed. complately (Check only one) 29b. Signetury and the about the 29c. License number 29d. Date signed (Month, Day, Year) 205 ovember 21,1989 uno 30. Name and address of person who completed cause of death (Nom 23a) (Typa, Print)
W. A. R. (27 GBM (6701 A Balto and 21204 bronle 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar 1999

F20 10 0 gr

State of Maryland / Department of Health and Mental Hygieneg Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** DOUGLAS LUTHER DAPP 5:30 AM 29, 1999 November /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 8523 Harris Ave. Parkville Baltimore If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours Months 180 M 2□ F Yrs 218-38-4201 58 Director Sept. 8, 1941 Washington D.C. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☒ No Director Baltimore Md. Parkville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiana. ther than "natural", or flema 23a or 8523 Harris Ave. 21234-4901 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Armed Forces r
1 Elyes 2 No
If Yes, Give
Year or Dates: Vietnam Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cosmetic Glass Elementary/Secondary (0-12) College (1-4or 5+) Accountant Co-ordinator Manufacturing Baltimore, Maryland 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) Be Peges 1 and 2 should be family and Mental I nt: If ham 27 is marked of Luther Dapp C. Dorothy Beach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gloria B. Dapp/wife 8523 Harris Ave. Parkville, Md. 21234-4901 Itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any Injury or page. = 5 4 ☐ Donation 5 ☐ Other (Specify) 12/3/99 Hilltop Service Corp. Towson, Md 22. Name end Address of Fecility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 23a. Pert 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician metastatie mesothelione /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): 880 P.O. algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? page 2 s 200 N 2 1 N 1 Yes Division of Vital Physician: funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 8 Other (Specify) After this 27. Manger of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 16 Natural 2 Accident or Attending 5 Pending investigation s after deeth. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The call Examiner: On the basis of examination and/or investigation in my online death accurred. 29a. Certifier edical er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only 29c. License numbe 29b. Signature and talk of certifier 29d. Date signed (Month, Day 30. Name and address of person who completed cause of death (ffam 3a) (Type, Print) Richard Huslig, 7505 M.D. Osler Suite 302 Towson, MD, 21204 Dr. 31. Date filed (Moor Fue), Year 1999

DHMH 16 Rev 6/95

State Registrar 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

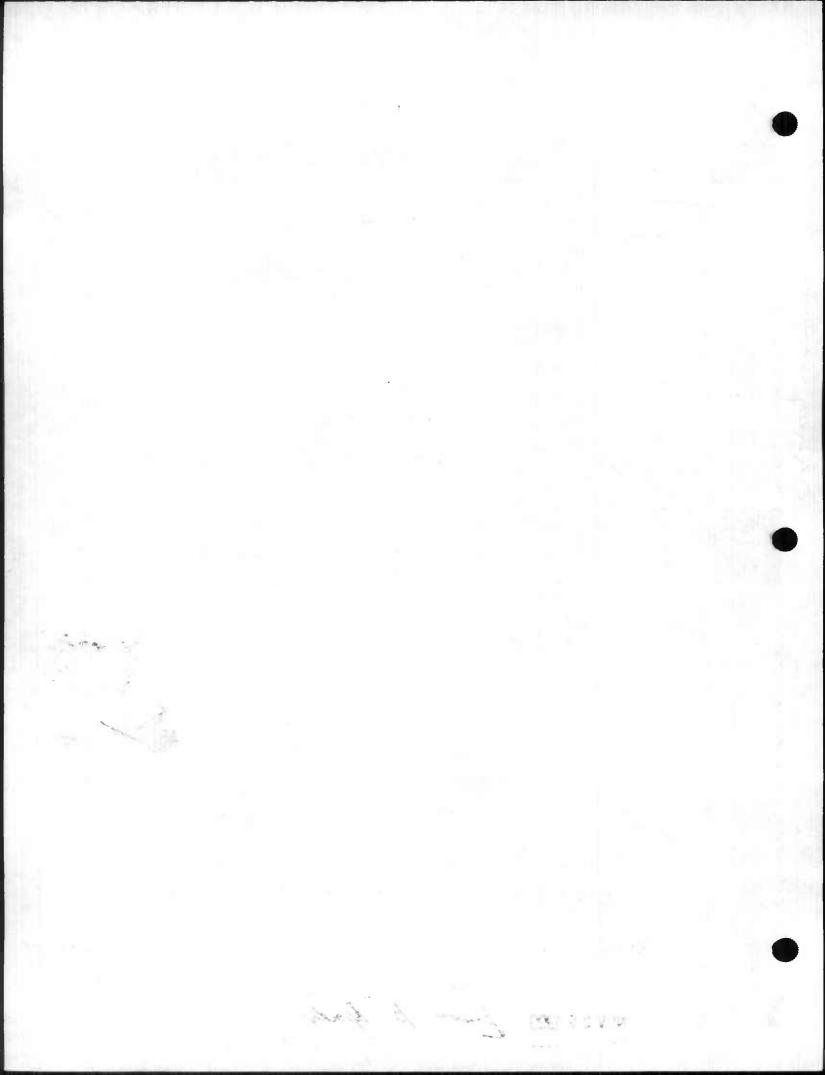
	(First, Middle, La	est)			rtificate of			ate of Death		Mass'	3. Tima of Death
n al	SHIRLEY			D	ANSICKER			Nonth VEMBER	R 24, 1	Year 999	5:00 PM
4a Facility Name (If n	-		nber)			4b. City, Tow			4c. County		
124-A HAR 5. Social Security Num			7. Age (In yrs. la	last birthday)	If Under 1 Year	OWINGS			BALTI		ace (State or Fore
214-20-58		□M 28 F	72	Yrs.	Months Days	Hours	Min. (A	ate of Birth Month, Day, 1	Year)	Coun	ace (State or Fore try) MD
Usual Residence of D	Decedent 10b. County		10c City	, Town or Lo	cation					146	d. Inside City Lim
	BALTIMO	RE.		INGS M						- 1"	1 ☐ Yes 2 ☑ f
10e. Streef and Numb			0	21100 11	10f. Zip Code			100	g. Citizen of W	/hat Coun	try?
124-A HAR	RRY LANE					21117			U.S.A		
11. Marital Status	a of Water day	Armed For		S. 13. V	Was Decedent of f Yes, specify Cul	Hispanic Origi ban, Mexicen,	n? (Specify) Puerto Ricar	res or No- n, etc.)		e - America k, White, e	
1 ☐ Never Married 3 ☐ Widowed 4 [1 ☐ Yes If Yes, Give Year or Da	0	1	1 ☐ Yes 2 📉 No	Specify:			Specify:		WHITE
	15. Decedent's Ed y only highest gra			16a. Deced	dent's Usual Occu	ipation	of working	16	6b. Kind of Bu	siness/Ind	ustry
Elementary/Second		College (1-	-4or 5+)	life. L	DO NOT use retin	ed)	Ji WOIKING	7	LIEOMOD	TT D	NA DOC
17. Father's Neme (Fit	irst. Middle, Lasti)		OWNER		18. Mother	s Name (Firs		AUTOMOB aiden Sumame		PARIS
SAMUEL				BERLI	N	YETT					OVAK
SAMUEL 19a. informant's Name				100000000000000000000000000000000000000	ng Address (Stree					State, Zip	
STANLEY D		R / HUSE			HARRY L	ANE - (-			
20a. Method of Dispos	Cremation 3		State	emetery, cren	sition (Name of natory or other pla		Da		0c. Location - (
4 Donation 5			BETH		B CEMETE . Name and Addr		11/2	6/99	FINKSB	URG,	MD
Miller	Level 7	1000									S., INC.
23a Parf1. Enter the shock, or heart for	disease or com	plications that ca	used the death	Do not ente	900 REIS	TERSTO	WN ROA	D PI	KESVIL	LE, N	Approximate
Immediate Cause (Fir diseese or condition resulting in deeth)	inel	. N			ic Cole					oran	
diseese or condition resulting in deeth)		b	Due to (or	r as a consequence as a consequence	uence of):					oran	
disease or condition resulting in deeth) Sequentially list condition in many leading to immediate the cause Extra Hodericans	ditions, nediate ying njury	b	Due to (or	r as a conseq	quence of):					oran	
disease or condition resulting in deeth) Sequentially list condition and the cause. Enter Underly Cause (Disease or injust intuition in death) Las resulting in death) Las	ditions, nediate ying njury	b	Due to (or	r as a conseq	quence of):					orga	
disease or condition resulting in deeth) Sequentially list condition in an including to immunicause. Enter Underly Cause (Disease or injust in initiated events resulting in death) Las	ditions, nediate ying njury	b c	Due to (or	r as a conseq	quence of):					oran	Onset and Death
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DHMH 16 Rev 6/95

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Funeral Director

permit. Pages 1 and 2 ahould be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if lien 27 is merited other than "natural", or thems 23s or 28e-f show amportant: if lien 27 is merited other than "halfical Examiner must be notified at spice. Baltimore, Maryland 21215-0020

Mary

Dinatale

Physician /Medical Examiner

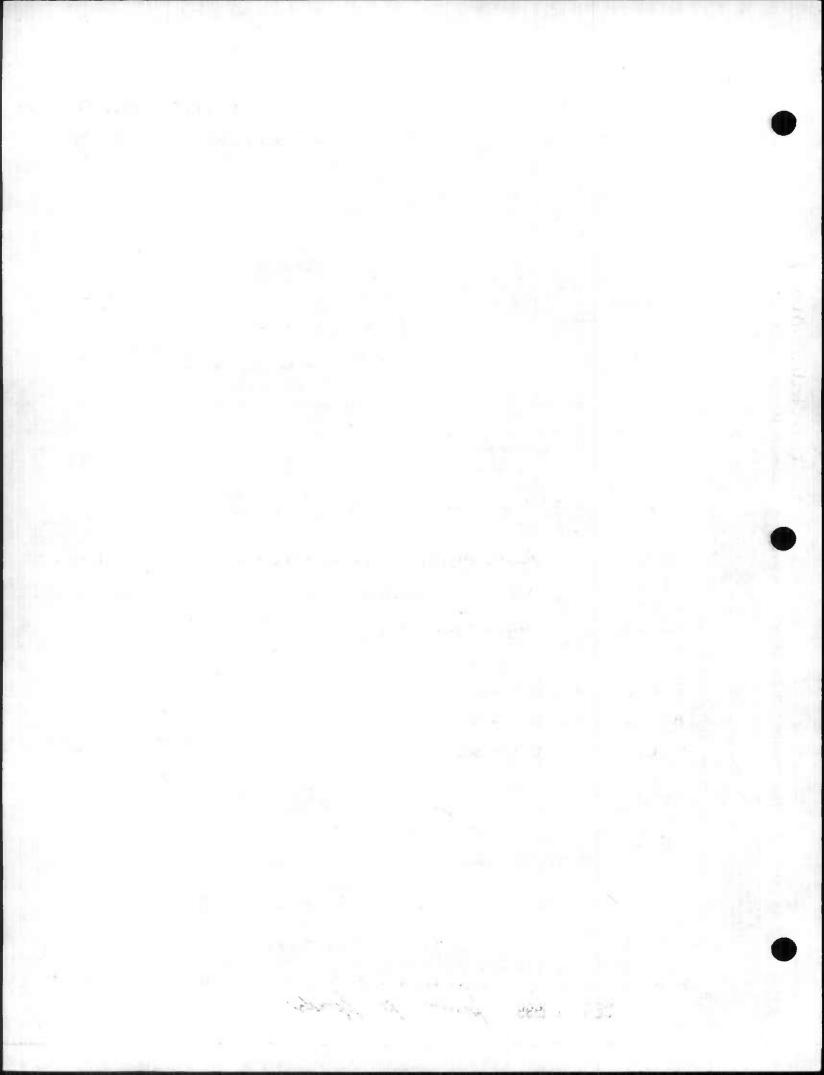
To the Mospital or Attending Physician: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Registr DHMH 16 Rev 6/95

		Certinic	cate of L	Jealii			Reg. No.		
Decedent's Name (First, Middle, Last MARY FRANCES	DI NATALE					2. Date of D Month NOVEm	ber 28	Year 1999	3. Time of Death
216 -07 - 0333	Hospital a	s. last birthday) If U			ed	8. Date of Bi (Month, D April	Bal	9. Birthpla	ce (State or Fore
Usuel Residence of Decedent 10a. Stete 10b. County		City, Town or Location				-		100	d. Inside City Lim
MD Baltir	nore		Essex	C					1 Yes 20
10a. Street and Number 619 Dunwich Way		10f	f. Zip Code	1221			10g. Citizen of		y?
11. Meritel Stetus 1 □ Never Merried 2 ☑ Merried	7 12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give	If Yes,		spanic Or	n, Puerto	pecify Yes or N Rican, etc.)	Ble	ce - America ck, White, et y: Whit	c.
3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	Year or Detes:	16a. Decedent's 1		ition		cina	16b. Kind of B		
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17. Father's Neme (First, Middle, Last)				18. Mothe			e, Maiden Sumer	ne)	
Archabald Bro		19b. Meiling Add	tress (Street a	und Numb			awes ber, City or Town,	. Stete. Zip C	Code)
Nicholas DiNatale		619 Dur					Maryland		
20a. Method of Disposition 15 Burial 2 Cremetion 3 F		. Place of Disposition cemetery, cremetory	(Name of	-	1	Date	20c. Location	- City or Tow	n, State
4 □ Donetion 5 □ Other (Specify)	PA	Arkwood Cen	metery	12	/1/9	9	Balti	more	Md.
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



Hygiene

JOHN	State of Maryland / Department of Health and Mental
ERNST	Certificate of Death

37584

Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** JOHN S ERNST JR. NOVEMBER 26,1999 8:40P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 3123 STAFFORD AVE BALTIMORE If Under 1 Year Hours Min. 8. Date of Birth (Month, Day)
June 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Months Days 215-09-9952 DOM 20 F 82 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location worle 10d. Inside City Limits "naturel", or Nema 23s or 28s-f showed call Examiner must be notified at Md Baltimore Baltimore Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3123 Stafford Ave. 21229 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. be filed within 72 hours after do tel Hyglene.
d other than "naturel", or frem event, the Medical Examples. Bleck, White, etc. t√Yes 2 No Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Dock Worker Acme Food 7 is marked other altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill mant of Health and Mentel Hant: If Itam 27 la marked oth Jury or other traumatic even 8 John Ernst Mary Seekfreid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Regina M. Allen / Daughter 3434 Winter Moss Court Abington Md. 21009 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State pemit. Page Depertment of Important: if eny injury or page. Garrison Forrest Cemetery 12/3/99 Owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or compositions that coused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only the cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Examiner Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed physician and s the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): for use as 88 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy INSPECTION page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

of Vital 8 Certification: To

certificate or Attending Physician: funeral director. this After i efter deeth. I Director: Aft of in by the fur To the Hospital or A within 24 hours effar To the Funeral Direcompletally filled in b

Division

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death XXNatural

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Hospitel: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28b. Time of

Other: 4 Nursing Home 5 Nursing Home 5 Nursing Home 8 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

O.C.M.E.

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

NOVEMBER 27, 1999

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner period. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID R. FOWLER M.D. 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

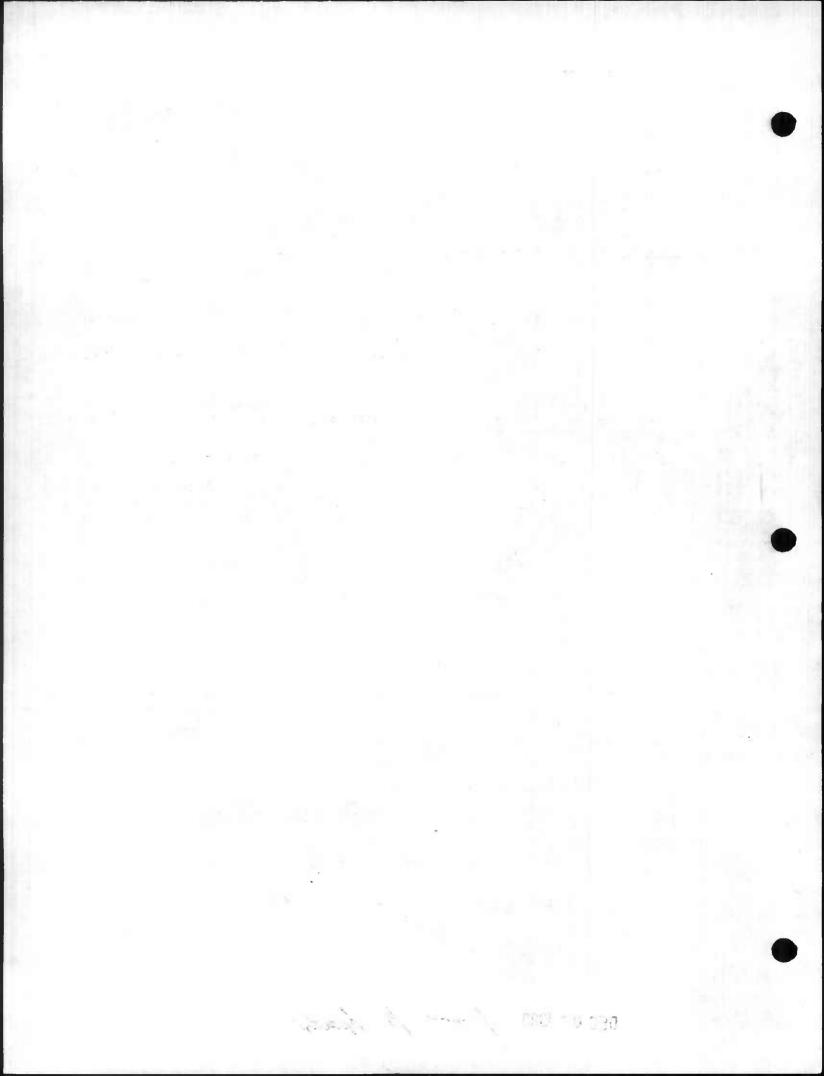
X

Medical

DEC

32. Registrar'e Signature

A	MEND 10e PER F.H. G778_1	State of Maryla		artment of F tificate of			ene 99	37585
Physician /Medical	Decedent's Name (First, Middle, Last SHIFRA)	F	RIDMAN		2. Date of Death Month NOVEMBE	Day Ye	3. Time of Death 99 12:50 AM
Examiner	4a Fecility Neme (If not institution, give				4b. City, Town, or I		4c. County of D	
	6962 MILBROOK PAR 5. Sociel Security Number 6. Se		D . last birthday)	If Under 1 Yeer	BALTIMON If Under 24 Hrs.		BALTIM	ORE Birthplace (State or Foreign
Funeral Director		M 2Å F 74		Months Days	Hours Min.	8. Date of Birth (Month, Day, JUN . 11,	1925	Country) UKRAINE
Du .	Usual Residence of Decedant 10a. State 10b. County	100.0	ity, Town or Lo	cation				10d. Inside City Limits
the Maryland 28e-f show notified at								1 ☐ Yes 2 X No
r 28a-f	10e. Street and Number	CE B	ALTIMOR	10f. Zip Code		10	g. Citizen of What	Country?
th with 23e or	6962 MILBROOK PAR	RK DRIVE #1-	D		21215		U.S.A.	
Hems December	11. Merital Stetus 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No H Yes, Give Year or Detes:		Wes Decedent of H Yes, specify Cub □ Yes 2☑ No	dispante Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		vmerican Indian, Vhite, etc. WHITE
21215-0020 d within 72 hours af giene. Then 'natural', or then 'natural', or the Madical Exert.				lant's Usual Occup	pation during most of wor	tring 1	6b. Kind of Busine	ess/Industry
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Maryland d 2 should be file th and Mental Hy T is marked oth traumatic event	19a. Informant's Neme/Relationship (Ty	pe, Print)			end Number or Ru	ıral Routa Number,		ta, Zip Code)
s 1 and 2 should be filed in the alth and Mental Hydrogother traumatic event,	SAMUEL FRIDMAN /				PARK DR			E, MD 21215
0 0 0 7 5	20a. Method of Disposition 1 Description 2 Cremation 3 F	lemoval from State	cemetery, cren	sition (Neme of natory or other pla			0c. Location - City	
Baltim Department Meportant: Insportant: I	4 Donation 5 Other (Specify) 21. Signature of Funeral Segree License			CEMETER Name and Addre		11/22/99	OWINGS	MILLS, MD
Balt permit. Departr fmporta any light page.	> Jeus (Vay)	Cen	8	900 REIS	TERSTOWN	ROAD - P	IKESVILL	BROS., INC. E, MD 21208
Physician /Medical Examiner	23e. Fart / Enter the disease, or combi- shoot, or hyan failure. List only of Immediate Cause (Final disease or condition resulting in death)	Right Dua to	Cour (or as a conseq	e Ca				Approximate Interval Between Onset and Death Question Conset and Death
ate be associted hysician and the bunial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):	mers.			
	Cause (Disease or injury that initiated evants resulting in death) Last	Due to (or as a consequ	uence of):				
death cert death cert e attendin e attendin ed for use sician/M	Pert II. Other significant conditions cor	stributing to death but not re	culting in the ur	derhina cause ci	en in Part I	23h Did to	necco una contrib	oute to the cause of death?
Is, P.O. Box 6 es that the death certific igned by the attending p be detached for use as by Physician/Me	hypoxia	in bothing to death) but not re	Sound III the O	idenying cause gi	on are all i.			Probably 4 Unknown
requirer seen signal thould be ted	, ,					24a. Was an perform	eutopsy 24	4b. Were autopsy findings evailable prior to completion of cause of death?
						1 ☐ Yes	s 2 0 No	1 Yes 2 No
f Vita ysicien: is certifica director,	25. Was case referred to medical examiner?			Lav		ith (Check only ons)	
— > = -	1 ☐ Yes 2 ☐ No 27. Manper of Death		ER/Outpatien	1 3LI DOM		lome 5 X Resider		Specify)
on offing th. After fune	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injur Wo M 1 □	rk? Yas 2 □ No	200. Describe no	w injury occurred	
Division of the order of the result of the country	3 Suicide 6 Could not be 4 Homicida datarminad	28a. Place of Injury - At I building, etc. (Spec	nome, farm, stre ify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number o Stata)	r Rural Route Number,
Division of To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of Medical Certification: Te	29a. Certifier 1 Certifying Physics (Check only one) 2 Medicat Examin	sician: To the best of my kn ner: On the basis of examin and manner steted.	owledge, death ation and/or inv	occurred at the tirestigation, in my o	ma, data and place ppinion, daath occu	, and dua to the car rred at the time, da	usa(s) and manne ta and placa, and	r as stated. dua to the causa(s)
To the within To the comp	29b. Signature and title of certifier	711		29c. Licens			d. Date signed (M	Ionth, Day, Year)
1-	1. A Poleo	MD			0547	46	112119	7
D	30. Name and address of person who co A-PoCoV, m.D 68	impleted cause of death (Italian)	m 23a) (Type, I	Print)	Balla is	112/215-11	131	
State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign	ature			17 (100 1000)	01	
Registrar	DEC 0 1 19	399 Dener		ba	11.			



State of Maryland / Department of Health and Mental Hygiene 99 37586

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	1. Decedent's Name (First, Mide	idle, Last)								2. Date of Dee		Veer	3. Time	of Death
ian cal	BENN	Y		Н				FEIT		NOVEMBE NOVEMBE	ER 20,	1999	7:05	5 PM
	4a Facility Name (If not instituti	ion, give st	reet and number	or)			- 1	4b. City, To	wn, or Lo	cation of Death	_	ty of Death		
	SINAI HOSPITA	L						BALT	[MORI	Ξ	N/A			
	5. Social Security Number	6. Sex		Age (In yrs. I	C	If Under	T 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (Stat	a or Foraig
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	3 ☐ Widowed 4 ☐ Divorce		If Yes, Give Year or Date	WWI	I	1 ☐ Yes	2 X No	Specify:			Spec	ty:	WHIT	E 2
-	15. Decede	ent's Educe	etion		16a. Dece	dent's Usu	at Occup	ation			16b. Kind of I	Business/In	dustry	
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	HARRY			FE	IT			MAY			SCHI	FELDR	IN	
	19a. Informant's Name/Relation	nship (Type	e, Print)		19b. Maili	ng Address	S (Street	and Numbe	er or Run	al Route Numbe	r, City or Town	n, State, Zip	Code)	
	ROSE FEIT / W	IFE			6317	PARK	HEIC	GHTS A	AVEN	JE #621	- BALT	IMORE	, MD	21215
1	20a. Method of Disposition	- 60-			ace of Dispo	sition (Name	ma of other place	oe)	1	Data	20c. Location	- City or To	own, State	
	1 N Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (movei from Ste	RODI	E ZED	EK CE	METE	ERY	11	L/22/99	BALT	IMORE	, MD	
	21. Signature of Juneral Service	e Ligenses	0 ,1	2	22	2. Name ar	nd Addre	ss of Fecili	У	SOL LEV	TNISON	& BDO	S	NC
	NOA	MI	.TH	1	8	900 F	RETST	PERSTO	WN F	ROAD - F				
+	23a. Peril. Enter the disease, o	or complica	ations that caus	ed the death									Approxim	nate
	shock, or heart failure. Lis	st only ona	cause on eecr	line.								1	Onsat an	d Death
	immediata Cause (Final disease or condition			1.	SCU	n							11	j
	rasulting in death)	a.			as a consec	ALTERNATION IN		_				1	una	non
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i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					30C2111 23								
111	Cause (Disease or Injury that initiated events resulting in death) Last	C		Due to (or	as a conseq	uence of):								
	rosuming in obtain base											1		
		d.,										1		
F	Part II. Other significant condit	d	ibuting to death	but not resu	iting in the u	nderlying o	ausa giv	en in Part I		23b. Dld 1	obacco una c	ontribute to	o the caue	s of death
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-	Part II. Other algnificant condit	d	ibuting to death	but not resu	iting in the u	inderlying o	causa giv	en in Part I			res 2□No	3 ☐ Prof	bably 4	y tindings
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99-7005-510 DDG Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. JINAYA GRAVES 3/8/00 State of Maryland / Department of Health and Mental Hygiene amend item 23a,27, 28a,b,c,d,e,f per me G781 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** NOVEMBER 22, 1999 1013 AM JINAYA S. GRAVES /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ST. AGNES HOSPITAL BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Veer 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Z Hours 10 M 20 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County BALTIMORE 1 Hes 2 No Director 258-7 10a Street and Number 10g. Citizen of What Country? USA 21229 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mentel Stetus 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Hern 27 is marked other than "natural", or its ☐ Yes 2 ☐ No f Yes. Give 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) NIA 0 Saltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be GRAYES 19b. Meiling Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) W. 19e. Informent's Neme/Reletionship (Type, Print) 20b. Plece of Disposition (Name of cametery, cremetory or other place) if of Health a if them 27 is or other tra BIAL TO MD 212
Dale 206. Location - City or Town, State GRAVES RED W. 20e. Method of Disposition Date 1 Buriel 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) KING MEMORIAL 22. Name and Address of Facility
HOUGLL FITH HEIGHTS AVE. BATTO. MD, 21207 21. Signature of Funeval Service Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical SUDDEN UNEXPECTED DEATH IN INFANCY Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of) 987 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Ves 2 No 1 Yes 2 No Attending Physicien: 25. Wes case referred to medical examiner? Medical Certification: To Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | Text Outpatient 3 | DOA 1 No 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Menner of Death 28a. Dete of Injury fou (Manth, Day Year) 11/22/99 28b. Time of fou (Manth, Day Year) 9:2 A 28d. Describe how injury occurred Unknown 28c. Injury et Work? After Division 5 Pending investigation 1 Netural death. 9:20M 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Yes100000 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5/, C Oultrand Change 4 Homicide 54 S. Culver Street Paltimore, MI.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steled. 29e. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number O.C.M.E. NOVEMBER 23, 1999 Miles

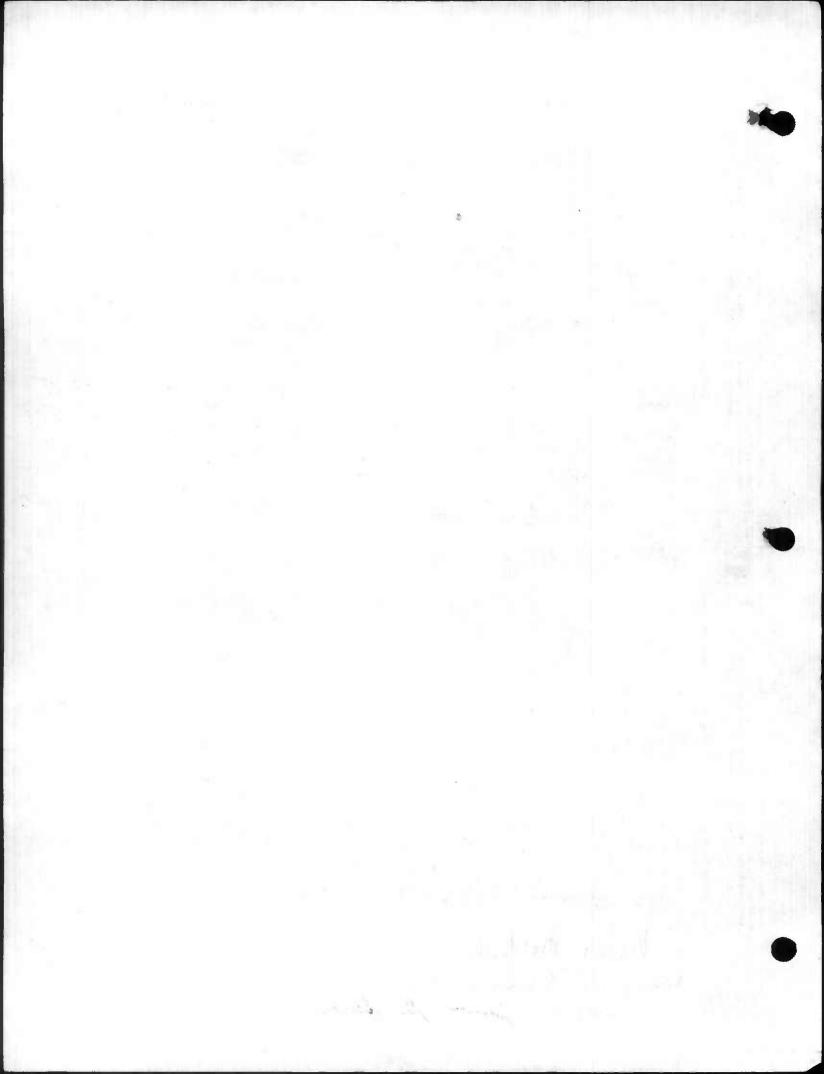
State Registrar

1DRYDOUTS 31. Dete filed (Month, Dey, Year)
DEC 0 1 1999

30, Neme end address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrer's Signeture

A. KORFU My 111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene OO

				Certificate	of Death	7	Re	g. No.	3	3/588
Physician	Decedent's Neme (First, Middle, L.	ast)		GOT DI	33.00		Date of Deeth		Year	3. Time of Death
/Medical	POISHE			GOLDI			JOVEMBE		1999	4:37 PM
Examiner	4e Facility Neme (If not institution, gr STELLA MARIS HO					own, or Locat ONIUM	ion of Death	4c. County BALT	of Death IMORE	
Funeral Director	214-94-4489	Sex XXM 2□ F	e (In yrs. last b		Year If Unde Days Hours	Min.	Date of Birth (Month, Dey, JUN • 15,	Year) 1914	9. Birthpi Count	lace (State or Foreign try) UKRAINE
pu »	Usuel Residence of Decedent 10e. Stete 10b. County		10c City Toy	vn or Location					11	0d. Inside City Limits
danyle f sho				IMORE					- 1"	1 Yes 2 No
the post	10e. Street and Number			10f. Zip C	ode		10	og. Citizen of V	Vhet Coun	try?
offer death with the Ma in theme 23a or 28a-1 s one must be notified Finneral Director	5902 PARK HEIGH	TS AVENUE	#502		212	15		U.S.	Α.	
dear	11. Merital Stetus	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Was Deceder If Yes, specify	nt of Hispanic O	rigin? (Specif	y Yes or No-		e - America k, White, o	
by by	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Detes:	No	1□ Yes 2k			, 5,6,7	Specify		WHITE
72 hours "natural",	15. Decedent's E (Specify only highest g		164	Decedent's Usual ((Give kind of work life. DO NOT use	Occupation done during mo	st of working	1	6b. Kind of Bu	siness/Ind	lustry
illed within 72 hours at Hyglene. Whysene. Whysene. Whysene. Whysene. Chartest and a hygener.	Elementery/Secondary (0-12)	College (1-4or 5	5+) M	ANAGER	retired)			WARE	HOUSE	
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2 sho and is m	19e. Informant's Neme/Reletionship	(Type, Print)	19	b. Melling Address (S	Street and Numi	ber or Rural R	loute Number,	City or Town,	Stete, Zip	Code)
CENL	BETYA GOLDBERG	/ DAUGHTER		3 CORNBURY of Disposition (Nema						
2 2 2 2 2	20e. Mathod of Disposition 1 Burial 2 Communication 3 I		cemete	GTON CHIZU	er place)		Dete 2 /22/99	Oc. Location -		
	4 Donetion 5 Other (Spec	3/-/-	AKLIM	22. Name end		line				
permit. Department importations any injury police.	· All 1/1/1/	Nie a								NS., INC. MD 21208
Physician /Medical Examiner	Immediate Causa (Finel disease or condition resulting in death)	a		consequence of):	Can	cer				Onset and Death
certificate be executed vising physician and usa as the burial-transit	Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying	b	Due to (or es a	consequence of):						
flicate be experience of the purishment of the p		C	Due to /or on a							
E 0 5			Due to (or es a	consequence of):			٠			
eath cert ettendin For usa		d	_							
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been should							24a. Wes er perform	n eutopsy ned?	OOF	ore eutopsy findings allable prior to mpletion of cause deeth?
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certificate rector, pa	25. Wes case referred to medical				26. Plac	e of Deeth (C	Check only one			
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ing Phys After this funeral d	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Deta of Inju (Month, Day	ry y Year) 28b.		Injury at Work?		d. Describe ho	w injury occur	red	
tal or Attending P is after deeth. at Director: After ted in by the lunaric Certification:	2 Accident investigation 3 Suicide 6 Could not 1 4 Homicide detarmined	00 00	ury - At home, f c. (Specify)	erm, street, fectory, o	1 Yes 2		Location (Str City or Town	reet end Numb , State)	er or Rura	l Route Number,
Hospi 24 hou Funer (ely fill	29a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of	examinetion ar	e, death occurred et nd/or investigetion, in	the tima, data a my opinion, de	nd place, and eth occurred	due to the ca at tha tima, da	use(s) and ma	nnar as st	ated. the cause(s)
ithin 2 or the omple	29b. Signeture and this of certifier	and mennar sta	ned.		icense number			d. Dete signe		
or with	14:4-				47726		20	1112		

State Registrar 31. Dete filed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

TARIQ MALTMOUD 821 N. Evitaw St Suit 316 Baltimore MD 21201 32. Registrar's Signature

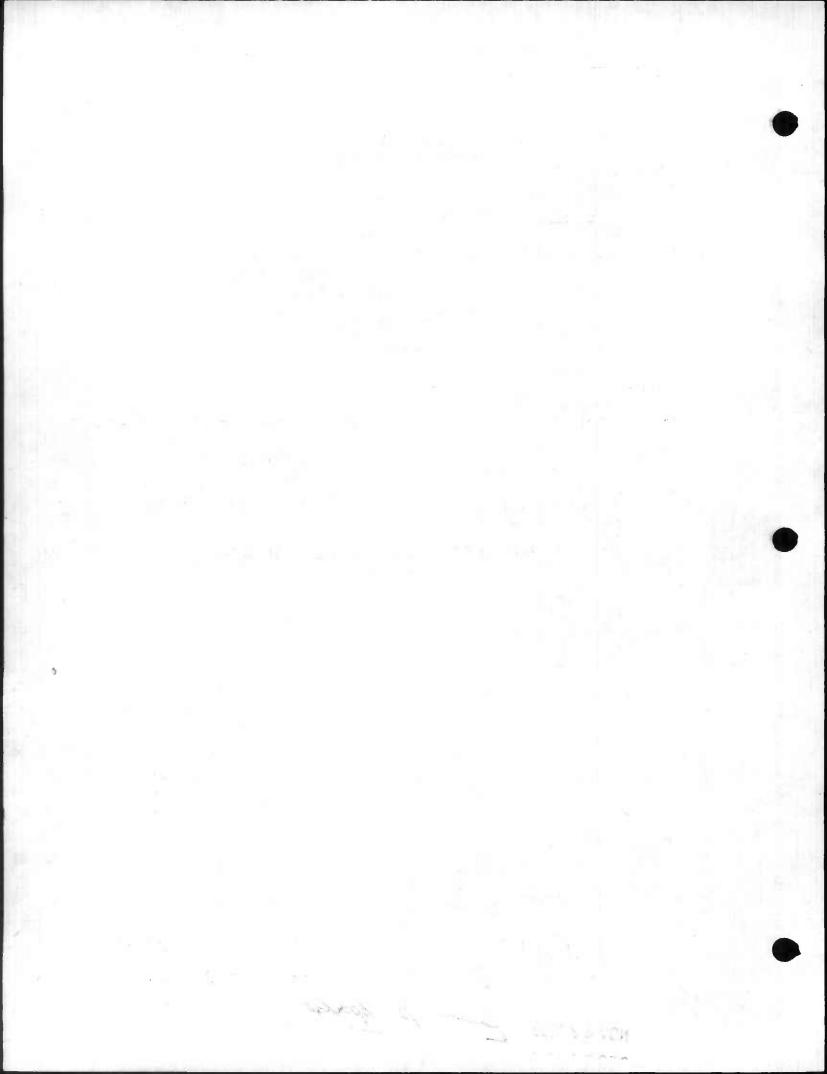
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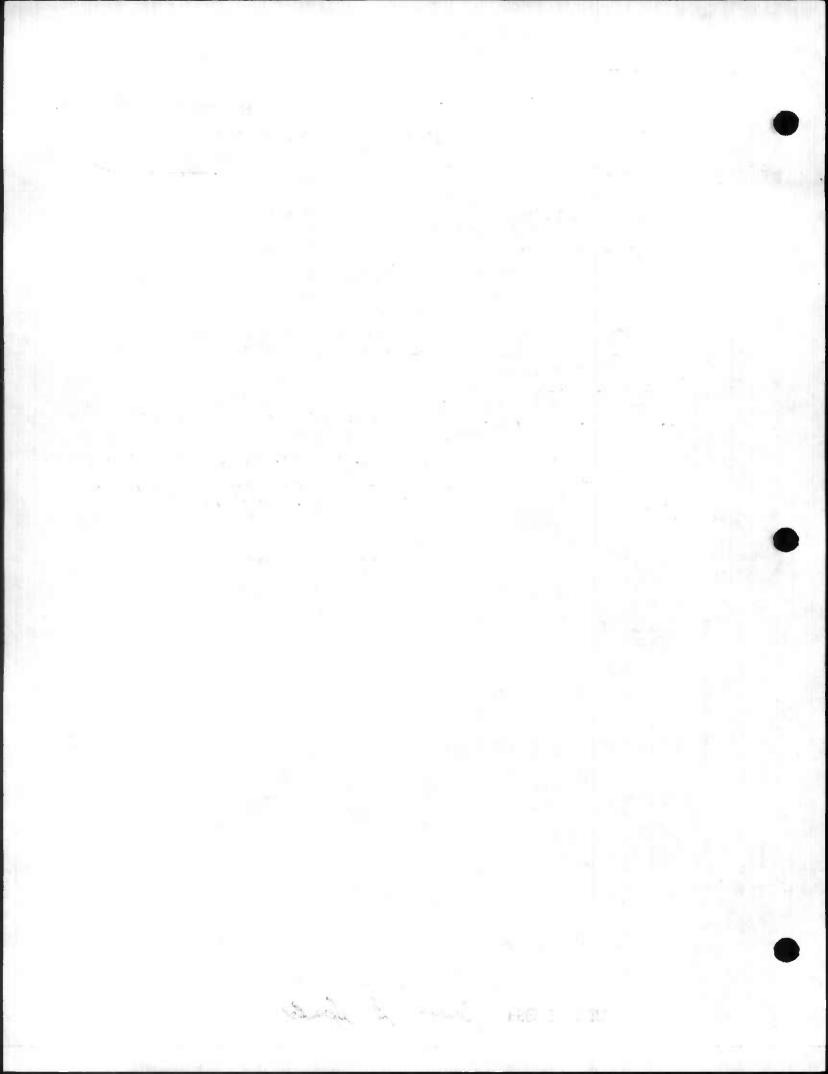
	1. Decedent's Name (Fir			•		ertificate of	Dodin	2. Date of De			3. Time of Death
ysician Aedical	FLOREN			K	120	(GORDON	NOVEMBI			10:45 AM
iner	4e Facility Neme (If not HOSPICE OF				OTOT C	סיביתותבים	4b. City, Town, or	Location of Deat			
	5. Social Security Number 216–05–6679	er 6. S		7. Age (In ye	s. last birtho	Months Days			BALT] th sy, Year) 1917		place (State or Foreign ntry)
	Usual Residence of Deci	edent . County		10c.	City, Town o	r Location					10d. Inside City Limits
Dil delle		ALM BEAC	H			BEACH					1 ☐ Yes 2 💢 No
ALC: N	10e. Street and Number		1,	1100		10f. Zip Code	20.405		10g. Citizen of U.S.A		ntry?
	5876 REGAI	2 Married		edent Ever in orces? 2 1 No	U,S.	13. Wes Decedent of I If Yes, specify Cub	oan, Mexican, Pue	Specify Yes or No to Rican, etc.))- 14. Re	ce - Americk, White,	
	3 X Widowed 4 □	Divorced Decedent's E	Year or D		160 D	ecedent's Usuel Occu			16b. Kind of B		WHITE
		nly highest gra	completed) College (1-4or 5+)	- (C	ive kind of work done b. DO NOT use retire MAKER	during most of we	orking	OWN H		cusity
	17. Father's Neme (First,	, Middle, Last)				18. Mother's Ne	me (First, Middle			
	HERMAN				KABI	K	RACHAEL			LE	ľY
	19e. Informent's Neme/F				19b. N	eiling Address (Stree	t and Number or F	tural Route Numb	er, City or Town	, State, Zip	Code)
	JERRY GORI	, ,	SON	last		02 KNOLLCF	REST ROAD				
	20a. Method of Disposition 1 X Burial 2 ☐ Cree	emetion 3		State	cemetery,	sposition (Name of cremetory or other ple		Date	20c. Location		
	4 Donation 5 21. Signature of Funeral			MO	SES MO	NTEFIORE (22. Name and Address		11/26/9	9 BAL	PIMOR	E, MD
	1	17	1800								S., INC.
	23a Part V Enter the die	Her	nlications that	caused the de	eth Do not	8900 REIST	ERSTOWN	ROAD - F	PIKESVIL	LE, N	
	23a. Part L Enter the dia shock, or heart fail	List only	one ceuse on	eech line.	om. Do not	onto the mode of dy	ing, such ea cardie	to or respiratory e	11031,	1	Approximete Intervel Between Onset end Deeth
	Immediate Cause (Finel		NON	SMM	J CE	u Lun	VC CAN	CIZR		1	N3 140
	disease or condition resulting in death)		a			sequence of):	v0 0) "	U	0	<u> </u>	7700
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	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury)	late	c							1	
	Cause (Disease or injury thet initiated events resulting in death) Last		0.	Due to	(or es e con	sequence of):					
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	Part II. Other significant	conditions	contributing to d	eath but not r	asulting in th	e underlying cause of	iven in Pert I	23h Did	tobacco vise co	ontribute t	o the cause of death?
		oonalaone c	onthouring to u	Outil Dut HOLL	SOUTHING WITH	o unuony ng causo gi	NOT III POICE.		Yes 2 No	. /	bably 4 Unknow
										T	
									en eutopsy ormed?	av	fere autopsy findings reliable prior to empletion of cause
									1	of	death?
								10	Yes 212No	1	Yes 2 No
	25. Wes case referred to examiner?	medical	Hospitel:				hor	eth (Check only	1/		Una A. 10
	27. Manufer of Death			of Injury oth, Day Year)	☐ ER/Outpa 28b. Tim	INEMI 3LI DON	4 Li Nursing	Home 5 Resi	how injury occu		M LONGTHOR
	1 Neturel 5 [2 Accident	Pending investigation		th, Day Year)	Inju		ork?]Yes 2∐No				
		Could not b	e 28e. Plece	of Injury - Ating, etc. (Spe	home, ferm	, street, fectory, office			'Street and Num wn, State)	ber or Run	el Route Number,
	29a. Certifier 12 (Check only one)	Certifying Ph Medical Exam	niner: On the b	best of my k asis of exami	nowledge, d	eath occurred et the ti r investigation, in my	ime, date end plac opinion, deeth occ	e, and due to the urred et the time,	cause(s) and m date and place,	anner as s	stated. o the cause(s)
	29b. Signeture and title of	of certifier	and man	ner steted.		29c. Licen	se number		29d. Date signs	ed (Month,	Day, Year)
	> //	MPC	sal	M		0	3043	3	11	26/9	9
	30. Name and address of	person who	completed caus	se of death (It	em 23a) (Ty \$1	pe, Print) BALT /	MORE	MO	2120	4	
	31. Dete filed (Month, Da	ly, Year)	32. F	legistrar's Sig	neture /	& Sport	h				
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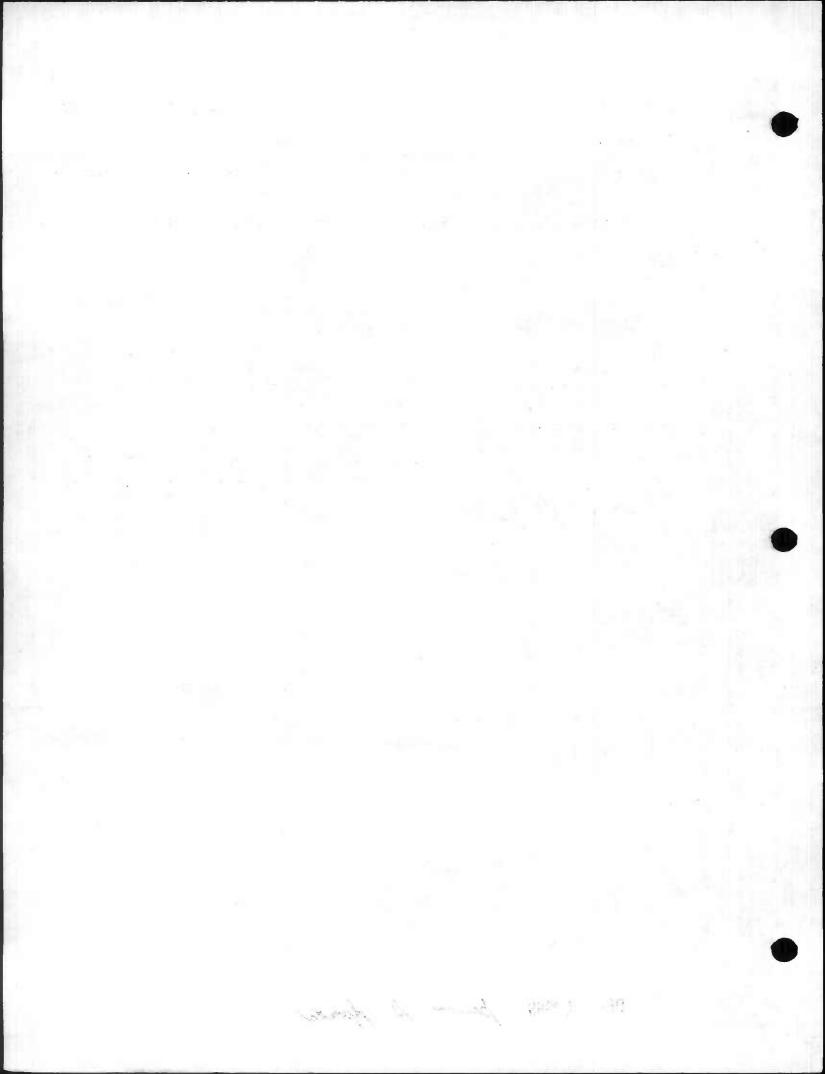


. Amended I	State of Maryland / Department of Health tem#8 perFHG778 12/8/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last)	
Physician /Medical	Martina M. Geigan	Month November 26 1999 11:35 pm
r Examiner		Imore City N/A
ire, Maryland 21215-0020 I and 2 should be liked within 72 hours effer death with the Maryland Health end Mentel Hygland. Health end Mentel Hygland. Items 27 is marked other than "natural", or hams 28 or 28s-f show other treumade event, the Medical Engline must be notified a control of the Completed by Funeral Director.	218-44-5139 1 M 20 F 53 Yrs. Months Deys Hours	24 Hrs. 8. Dete of Birth 1 – 31 – 46 9. Birthplace (State or Foreign Country) Jan 21,1946 Maryland
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Dung	10d. Inside City Limits
	Maryland Baltimore Dunction 10e. Street and Number 10f. Zip Code	1 ☐ Yes 2 ☑ No
	2854 Plainfield Road	21222 United States
	11. Merital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried 1 Yes 2 No If Yes, Specify Cuben, Mexica 1 Yes 3 No If Yes, Give 1 Yes 2 No Specify 1 Yes 2 No 1 Yes 2	n, Puerto Rican, etc.) Black, White, etc.
	12 Years 2 Years X-Ray Technician/ 17. Father's Name (First, Middle, Last) 18. Moth	er's Name (First, Middle, Maiden Sumeme)
	Walter 6. Wojerk	llian Roman
	19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number Mr. Eugene W. Geigan, Jr. 2854 Plainfield	er or Rural Route Number, City or Town, State, Zip Code) Road Dundalk, Maryland 21222
0 80 = 8	20a. Method of Disposition 1	m. 11/30/99 Parkville, Maryland
Balting	21. Signature of Fundral Sendon Licensee 22. Name and Address of Facili Duda – Ruck Funer	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between	
Physician /Medical Examiner	Immediate Cause (Finet disease or condition resulting in death) Due to (or as a consequence of):	Conset and Death
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected for use as the buriel-transit Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or es e consequence of): c. Due to (or es e consequence of):	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert	23b. Did tobacco use contribute to the cause of death?
		1 Yes 2 No 3 Probably 4 Unknown
		24e. Was en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death?
		1 Yes 2 No 1 Yas 2 No
	examiner? Hospital:	e of Deeth (Check only one)
	27. Mapner of Death Impatient 2 ER/Outpatient 3 DOA Impatient 2 ER/Outpatient 3 DOA Impatient 3	ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred No 28f. Location (Street and Number or Rurel Route Number, City or Town, State)
he Hospital in 24 hours a he Funeral is pletaly filled edical Ce		
To the comple	one) and manner steted. 29b. Signature and title of certifier 29c. License number	D40859 29d. Dete signed (Month, Day, Year)
0,5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	127m
	31. Date filed (Month, Day, Year) ~ 32. Registrar's Signeture	Bultime zuroz
State Registrar	DEC 1 1999 Denne & spark	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 9 Certificate of Death 1. Decedent's Nama (First, Middia, Last) 2. Data of Death 3. Time of Death Month **Physician** Madeline Gertrude Granese 3:00PM November 28,1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 319 Jody Way Timonium Baltimore Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Dafa of Birth (Month, Day, Year) **Funeral** Days Months Hours 10M 20F April 14,1929 Balto, 213-26-6144 70 Director Usuel Residence of Decedent Maryland 10a. Stete 10c. City, Town or Location 10d. fnside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director 280-71 Baltimore 319 Jody Way Timonium, MD 94 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 319 Jody Way 21093 USA flams 23s Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yas 2 ☐ No
If Yes, Give
Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien. 11. Marital Stafus "natural", or item adical Examiner Black, White, etc. filed within 72 hours after Hygiene. Rher than "naturel", or the 1 Nevar Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be liled w Department of Health and Mental Hygen Important; if Item 27 is marked other the any Injury or other traumatic Secretary Insurance Co, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Charles Joseph Delorenze Catherine Mary Trombetta 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19s. Informant's Neme/Relationship (Type, Print) 319 Jody Way Timonium, MD. Salvatore J. Granese 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 M Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Holv Redeemer Cem. 12/02/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD. 22. Neme end Address of Facility Dippel Funeral Home, Inc. 7110 Belair Rd. Baltimore, MD. 21206 not aused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause /Final 10 days pancreatic cancer Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) 88 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cerebovascular accident signed b h 24b. Were autopsy findings available prior to congestive heart failure 24a. Wes an eutopsy performed? Completed completion of cause of death? pneumonia 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Medical Certification: To Be 26. Place of Deeth (Check only one) Hospitel: 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Atter Attending 1 Naturel 5 Pending investigation 1 Yes 2 No To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1🗷 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner steted. 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) Hukle flashant 048050 30/90 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Timonium Medical Center Timonium, MD. Dr. Parahant Shukla 32. Registrar's Signature State Registrar

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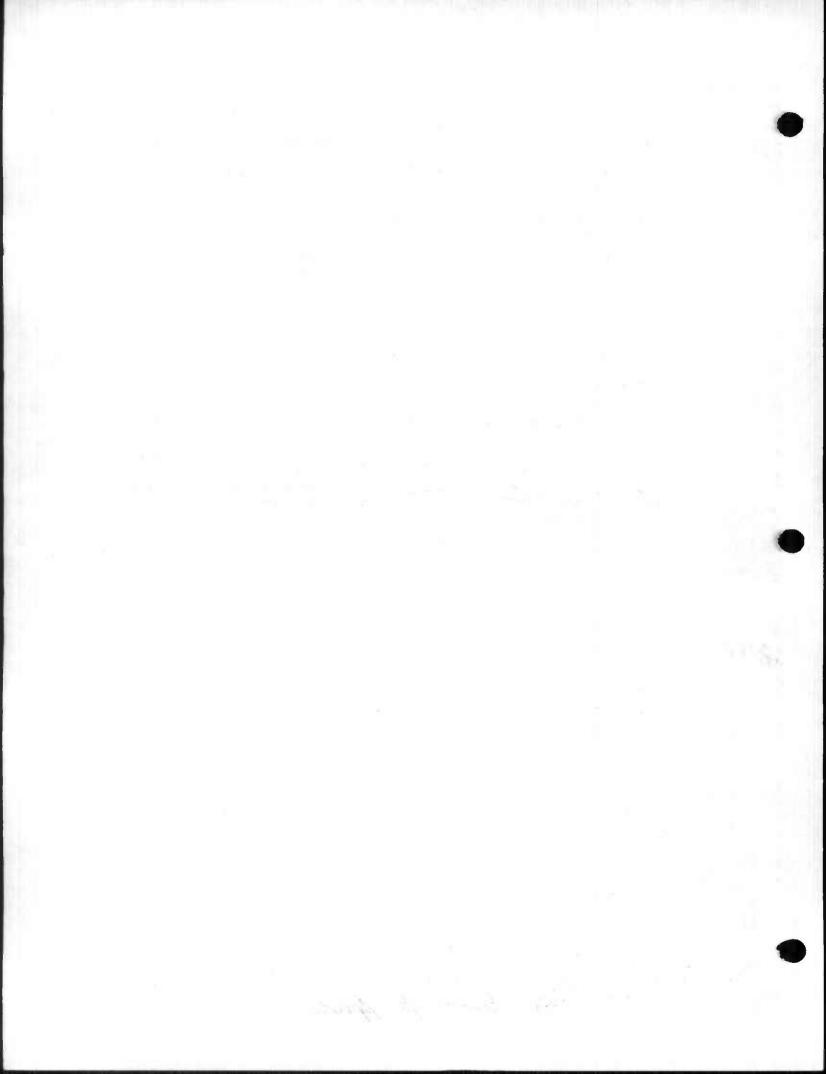


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State of Maryland / Department of Health and Mental Hygiene 99 3759

Physicia		Decedent's Neme (First, Middle, La	ast)	U	ortinodito of	Death	2. Dete of Dee	Reg. No.	3. Time of Dec
1 Hyalon	an		GRIN	MEC			Month	Dey Yes	er
/Medic		4e. Fecility Neme (If not institution, give		7E5		4b. City, Town, or Lo		27 199	
Examin	er		A 25 - 10 - 10 - 10 - 10 - 10 - 10 - 10 - 1					4c. County of D	eetn
	_	3021 HANLON AVE 5. Social Security Number 6.5		/Im come la n à la lathe de	If Under 1 Yea	BALTIMORE r If Under 24 Hrs.		N/A	
uneral irector			1 M 2 X X	(In yrs. lest birthda 93 Yrs.	Months Dey		8. Dete of Birtl (Month, De) NOV 14	7, Year) 9.1 1906 GI	Birthplace (State or Fo Country) EORGIA
show d at		10e. State 10b. County		10c. City, Town or	Location				10d. Inside City L
188	Director	MARYLAND N/A		BALTIN	ORE CITY				1 MAKES 21
or 2	in in	10e. Street end Number			10f. Zip Code			10g. Citizen of Whet	Country?
238		3021 HANLON AVE	NUE			21216		U.S.A.	
0.0	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☒️Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	rer in U,S. 1:	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ No	Hispenic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	On salf ii	mericen Indien, hite, etc. BLACK
ice in	ted	15. Decedent's E	ducation	ucation 16e. Decedent's Usual Oc				16b. Kind of Busine	ss/Industry
	Completed	(Specify only highest gro	ede completed) College (1-4or 5+)	life	ve kind of work don . DO NOT use retir	e during most of work ed)	ing		
other than	TO	8th grade	College (1-401 54)		MESTIC			HOME C	ARE
등 등	Bec	17. Fether's Neme (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumeme)	
0 0	To B	ELIAS COLEMAN				SOPHI	A COLEM	AN	
7 is marks traumatic	-	19e. Informent's Neme/Reletionship (Type, Print)	19b. Me	oiling Address (Street	et end Number or Run	el Route Numbe	r. City or Town. State	e. Zip Code)
2 6						Avenue, B			
om 2	-	Violetta E. Thom 20a. Method of Disposition	ipson/paugn	20b. Plece of Dis	position (Neme of		Dete	20c. Location - City	
		1XXXBuriel 2 Cremation 3		cemetery, c	rematory or other pi				
Important: If it any Injury or o once.		4 □ Donetion 5 □ Other (Special 21. Signature of Funeral Service Lice		-	RN STAR C		12-2-99	BALTIMOR	E, MARYLAN
sician		23a. Part1. Enter the disease, or or shock, or heart feilure. List only	plicetions thet caused the one ceuse on each line	ne deeth. Do not e	1206 W	C BROWN C NORTH AVEN ring, such es cerdiac	UE		Approximete Intervel Betwee Onset end Dee
edical miner	iner	Immediate Ceuse (Finel disease or condition resulting in deeth)	· Brea	ue to (or es e cons	ch Ccr sequence of):				6 mansh
hysicia the bur	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mitiated events resutting in death) Last	0.	ue to (or es e cons ue to (or as e cons					
50 m	-	L	d						
the atte	음	Pert II. Other significant conditions of	contributing to death but	not resulting in the	underlying ceuse o	iven in Pert I.	23b. Did to	obacco une contrib	ute to the cause of d
by the	Phy	Diabetes					1 🗆 Y	./	Probably 4 Un
o det	pleted by						24e. Wes e		b. Were eutopsy findi eveileble prior to completion of caus
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certificate has been signer rector, page 2 should be d	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospitel: 1 ☐ Inpatient	2 ☐ ER/Outpat	ient 3□ DOA O	Ma mare	h (Check only or	10)	1 □ Yes 2 No
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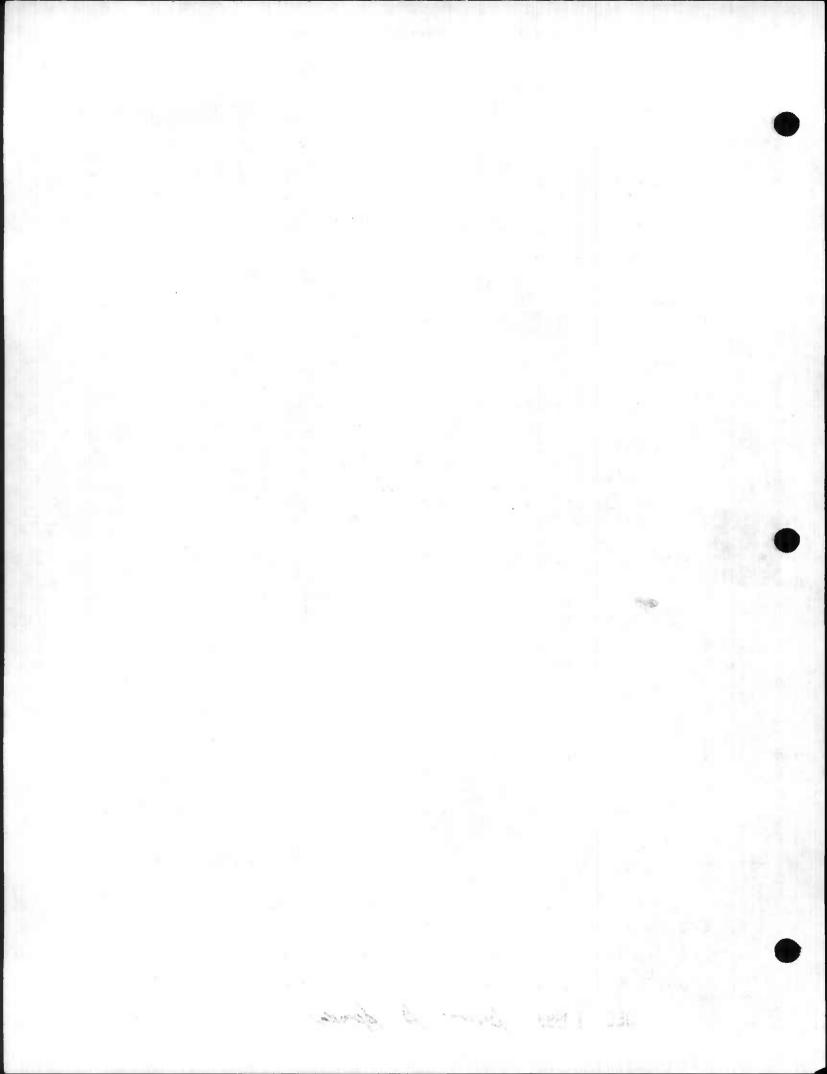


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended items 10e AMENDED1#24d9778 12/1/99 ah F778 12/1/99 DH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Vear Oscar Guzman Guzman /Medicai Nov 99 16 10:05 PM 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Advent Hospital Takoma Park
If Under 24 Hrs. 8. Dat Prince Georges 5. Social Security Number If Under 1 Year 8. Date of Birth Month Day, Year Jan 29, 1959 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 434-15-2430 1 X M 2 □ F Months Days Hours Min 40 Yrs. **Director** Guatumala Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified 1 ☐ Yes 2 ☐ No Director Montgomery Silver Springs 10e. Street and Number 1005 MERRIMAC DRIVE 10f. Zip Code 10g. Citizen of What Country? 20910 with 6 **GUATEMALA** 20903 238 Funeral death Unknown itams ; 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 XXNo If Yes, Give unknown Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status unknown ried 2□ Marrie the Medical Expression filed within 72 hours efter 1) Never Married 21215-0020 ŏ 1 ▼ Yes 2 No Specify: GUATEMALAN by Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) CHEF RESTAURANT unknownunknown unknown 6th unknown Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Mental marked unknown SARVELIO GUZMAN unknown ELFIDA MORALES traumetic ls ma 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown BYRON D GORDON unknown 8502 LEONARD DRIVE SILVER SPRING, MD 20910 If Item 27 other altimore, Pages 1 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) BARRIO RIO HONDO State ò 1 XXBurlal 2 Cremation 3 Removal from State Department Insportant: If any injury or otice. 5K)Other (Specify) in state FAMILY CEMETERY 12/7/99 GUATEMALA, C. A. C BACON, CC0361 22 Name and Address of Facility W H BACON FUNERAL 20010 State Anatomy Board 655 WASHINGTON, DC Baltimore, MD 21201 3447 art1. Enter the disease, or complications that dauged th nock, or heert feilure. List only one cause on each line. he death. Do not enter the mode of dying, such as cardiac or re spiratory arrest. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 2 WS disease or condition resulting in death) **Examiner** Examiner that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last pue Due to (or es a consequence of): physician Physician/Medical the Due to (or as a consequence of): Box Part II. Other eignificant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 3 0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 ☐ Unknown peugis Division of Vital Records. þ The law requires 24b. Were autopsy tindings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed been hes 1 Yes 2/03 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident death or Attend effer death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29 Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 11/18/9 30. Name and address of person who completed cause of death (item Cockrell 7600 Carroll ave . Joh. PK md. 20912 31. Date filed (Month, Day, Year) 32. Registra 's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 99 3759

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	/Medica	1 -	LILLI							NOVEMI		1999	unknown
	Examine	r	la Facility Name (If n	ot institution, giv	e street and numbe	Nr)			4b. City, To	wn, or Location of De	ath 4c. Cou	nty of Death	
		ų,			AVENUE			If Under 1		ORE CITY	N/Z	_	
	Funeral Director		5. Social Security Nurr 215-40-3 Usual Residence of December 19	635	ex /./ □ M 2XXI/F	Age (In yrs.	99 Yrs.		Days Hours	Min. (Month, I	Day, Year)		nplace (State or Foreign intry) RYLAND
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21215-0020	urs efter des al', or items racioner m	Dy ru	11. Marital Status 1 Never Married 3 Widowed 4	_	12. Was Deceder Armed Force 1 Yes 22 If Yes, Give Year or Dates	\$? \$No		Was Deceder f Yes, specify		gin? (Specify Yes or I , Puerto Rican, etc.)	14. F	Rece - Ameri Black, White, city:	
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	2 should and Men Is marke sumatic		19a. Informant's Nam	e/Relationship (Type, Print)		19b. Mailir	ng Address (5	Street and Number	or or Rural Route Nun	ber, City or Tov	wn, State, Zi	ip Code)
	and and 27 I		Constan	ce C. Wi	illiams/D	aught	er 17:	31 Bra	ddish Av	enue, Balt	imore,	Maryl	and 21216
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0			Part II. Other significa	nt conditions of	ontributing to death	but not res	culting in the u	nderlying cau	se given in Pert I.		AHOLES COLOR		to the cause of death?
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		5 2	7. Manner of Death 1 Dinatural	5 Pending	28a. Date of In (Month, L	ay Year)	28b. Time of Injury		. Injury at Work?		e how injury oc	curred	
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	1	3	0. Name and address	of person who	completed cause of	death (Iter	23a) (Type,	Print)	0 0-	00 01	HE ROW		
	Th.	1	MATULEY	SMI	IH MY)	5502	w.	KUTERY	B DUT	100	A M	UZKI
	State		11. Date filed (Month,			trar's Signa	ature /	1	1				
	Registrar		DE	1 199	19 24	perman		000	cks/				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth

1. Decedent's Name (First, Middle, Last) Month NOV. Physician 15 1999 Robert Benjamin Huggins /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince George's Examiner Hillcrest Hgts. 3912 20th Place Dete of Birth (Month, Dey, Year)
08 11 44 Charleston, SC If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1€ M 2□ F 55 250-74-8011 Director Usual Residence of Decedent with the Meryland 10c. City, Town or Location ms 23a or 28a-f show Prince George' Hillcrest Heights Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 20748 USA 3912 20th Place death Funeral r than "natural", or items the Medical Examinar ma 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indien, Bleck, Whita, etc. filed within 72 hours after Hygiene. Wher than "natural", or its 1 Never Married 2 Married 1 Yes 2 Tho
If Yes, Give
Year or Dates: altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mentel Physiens Important: if item 27 le marked other tha eny Injury or other traumatic event, that page. DC Govt. Laborer 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unkown Florence Huggins 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3912 20th pl., Hillcrest Hgt.,, MD 20748 Debra Huggins - wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) Washington Nat'l Cem. 11/19/99 Suitland, MD 22. Name end Address of Facility 21. Signature of Funerel Service Licensee Latney's Funeral Home 23a Cent1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. CC0348 **Physician** Adult T cell lenkeme /Medical Immediate Cause (Finel disease or condition resulting in death)

Examiner

P.O. Box 68760.

Records,

Division of Vitai

Examiner Physician/Medical p Completed 8 2

Certification:

physician end. s the burial-transit been signed by the should be detached ial or Attending Physician: The after death.

It Director: After this certificated in by the funeral director, pa

To the Hospital or A within 24 hours after To the Funeral Direcomplately filled in b edical State Registrar

27. Manner of Death

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

1 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical 26. Place of Death (Check only one)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury et Work? 5 Pending investigation

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

Due to (or as a consequence of):

28t. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner estated.

28d. Describe how injury occurred

24a. Wes en autopsy performed?

Other: 4 Nursing Home 5 Thesidence 6 Other (Specify)

1 Yes 2 No

Maul-he ortrod

6 Could not be determined

29c. License number D4670

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Day, Year)

PORMANENTE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Wera autopsy tindings evailable prior to completion of cause of deeth?

8:25 AM

10d. Inside City Limits

20011 Approximete Interval Between Onset end Death

months

NO Yes 2 No

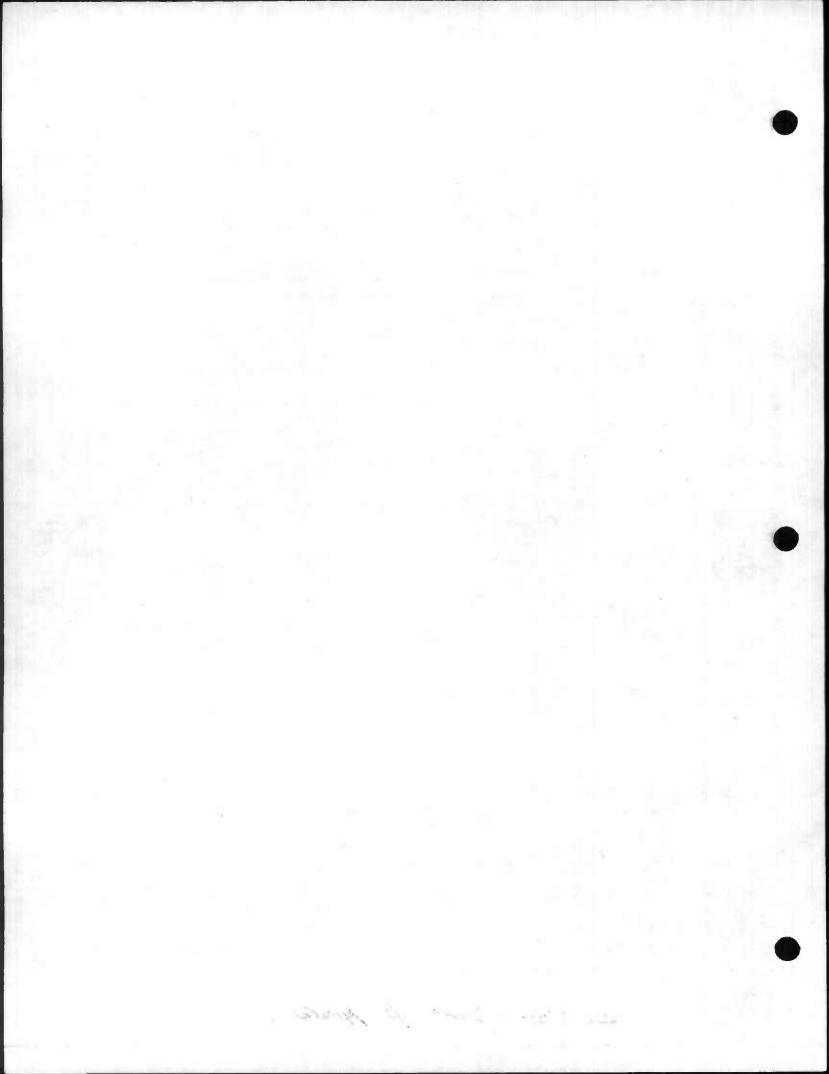
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KNTKONDE, LARSO M D MUTOMBO 32. Registrar's Signeture

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

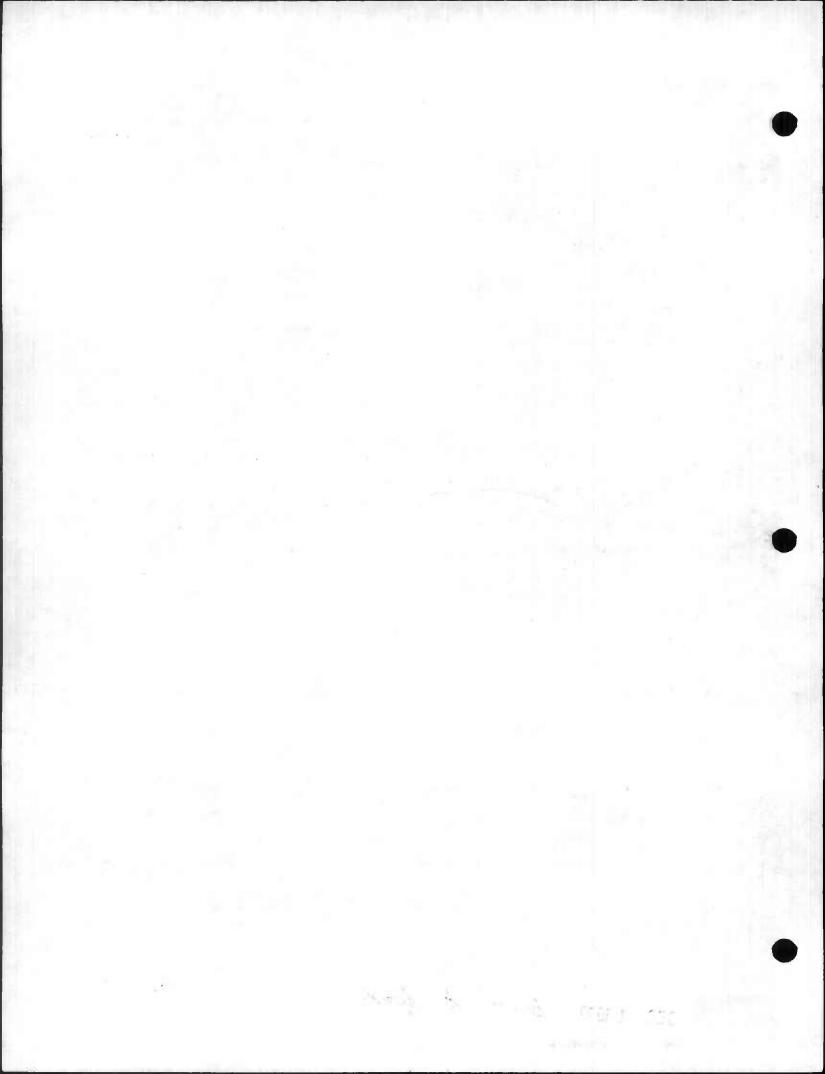
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dale of Death 3. Time of Death Day Month **Physician** Anna Hamlet November 28, 1999 8:30 pm /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3091 Sussex Place Riva, MD Anne-Arundel If Under 24 Hrs. Birthplace (Stata or Foreign Country) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M XX F 184-22-5087 70 Yrs Director PA June 21, 1929 Usual Residence of Decedent the Manyanc 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD Anne Arundel Riva Yes 2 No Director 230-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be 3091 Sussex Place 21140 United States 238 Funeral 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be flad within 72 hours after nent of Health and Mental Hygiene.

until if Nem 27 is marked other than "natural", or lies ary or other traumetic event, the Medical Examins 1 ☐ Yes 汉[No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes XX No Specify: White þ 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Own Home Saltimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) 89 Joseph Mossman Mary Knight 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elaine McLaughlin / Daughter 3091 Sussex Place, Riva Maryland 21140 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☎ Bernoval from State Department of Important: If any injury or page. Holy Sepiuchre Cemetery, December 2, 1999 Wynnmoor, PA 4 ☐ Donation 5 ☐ Other (Specify) hum of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** fmmediata Causa (Final disease or condition resulting in death) /Medical Lung Cancer Examiner Due to (or as a consequence of): Examiner Hypoxia The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical Due to (or as e consequence of) P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ★□Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of causa of death? been s Completed 24a. Was an autopsy performed? After this certificate has 1 Yes XXNo 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5224Residence 6 Othar (Specify) Certification: To 1 Yas & No s after death.
I Director: After this od in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Division X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) Illed in by 4 D Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53306 November 29, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Curtis Harris, M.D. 600 Ridgely Ave., Suite 231 Annapolis MD 32. Registrar's Signature 31. Data filed (Month, Day, Year) State 1 1999 DEC Registrar

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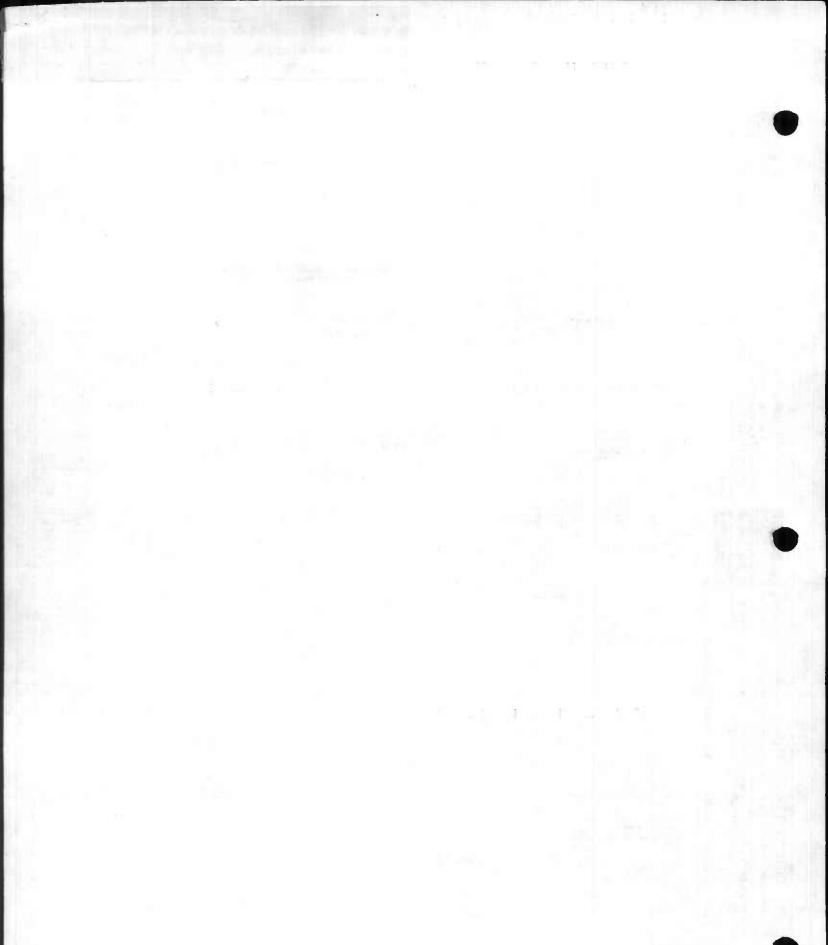
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Physicia	n	1. Decedent's Neme (Fin RAYM)		HOYLE						2. Date of De Month NOVEME	Day	3. Time of De 1999 9:28 F
/Medica Examine		6000 E. I			er)					cation of Deat MORE	h 4c. County	of Death N ? A
Funeral Director		5. Social Security Number 220–54–407 Usuet Residence of Dec	3	ex 7.	Age (In yrs. 49	last birthday) Yrs.	If Under 1 Yea Months Days		4 Hrs. Min.	8. Date of Bir (Month, De May 22		Birthplace (State or Fi Country) Maryland
or 28a-f show be notified at Director		10a. Stata 10b MD	Baltir	more							10d. Inside City L 1 ☐ Yes 2	
il Hydene. other than "natural", or flame 23s vent, the Medical Employ. must se Completed by Funeral	Dir	10e. Street and Number 6000 E. P.	ratt St	treet		10f. Zip Code 21224			24		What Country? JSA	
	Ď.	11. Marital Status 12 Never Married 3 Widowed 4		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dete	es? No		Was Decedent of If Yes, specify Cu		in? (Spe Puerto	ecify Yes or No Rican, etc.)	Specify	ck, White
	ompieted	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12th College (1-4or 5+)			16a. Deced (Give life. L	dent's Usual Occi kind of work done DO NOT use retir Disable	e during most ed)	of worki	ing	16b. Kind of Br	Kind of Business/Industry	
	B C	17. Father's Neme (First,		HOYLE			M				ma Bivens	ne)
9 5		19e. Informant's Neme/I		Type, Print)								, State, Zip Code)
Department of Health a Important: if Nem 27 is any injury or other tra pncs.		Karen Jaco 20a. Method of Disposition 1 Burial 2 Dicre 4 Donetion 5	on emation 3 🗆	1300 Dundalk Comparison of Disposition (Name of cemetery, crematory or other place of Disposition (Name of cemetery, crematory or other place of Crematory)				lace)	Date Date			City or Town, State
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State Registrar 29b. Signature and title of certifier

31. Data filed (Month, Day, Year) DEC 1 1999

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30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print)

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29c. License number

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

NOV. 27, 1999

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Please Type or Print in Black indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Date of Death Month **Physician** GLORIA NOVEMBER 24 1999 **JOHNSON** 10:30am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 199–34–6974 8. Date of Birth (Month, Day, Year) JAN.5, 1943 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2ØF 56 Director PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits ahow r than "natural", or items 23s or 28s-f show 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 1012 CROSBY ROAD U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, epecify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify: WHITE Specify by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. HOMEMAKER OWN HOME marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 end 2 should be nent of Heelth and Mental MARTIN KADEN LILLIAN **BROCKMAN** 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Important: If Nem 27 is any Injury or other trau WILLIAM JOHNSON / HUSBAND 1012 CROSBY ROAD - BALTIMORE, MD 21228 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Repr permit. Pege Department 11/26/99 SHAAREI ZION CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) ROSEDALE, MD 21. Signeture 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The lew requires that the death certificate be executed iclan and burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inflieted events resulting in death) Last Due to (or as a consequence of): edical physithe Due to (or es a consequence of) Physician/M USB signed by the at 1 be detached for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? pege 2 s 1□ Yes 2□ No 1 Yes 2 No Be 25. Wes case referred to medical 26. Place of Death (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Death 28c. fnjury at Work? 28d. Describe how injury occurred Certification: 1 Neturel or Attending 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** Ellsworth om Johnson 99 NOV /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA BON SECOURS HOSPITAL BALTIMORE If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 10 -29 - 39 9. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 10 M 2□ F Days Hours Months Min 214-38.5014 Yrs. MD 60 Director Usuel Residence of Decedent tha Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f ahov traumatic event, the Mexical Examiner must be notified at 12 Yes 2 □ No NA BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 21229 113 WILDWOOD PKWY. USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 72 hours aftar 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: BLACK by 3 □ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY OF PRIVER permit. Pagas 1 and 2 should be file Department of Health and Mental Hy, Important: If flem 27 is marked othe any injury or other traumatic event, bass. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARRY JOHNSON, SR SADIE AYDLOTTE 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 326 N. GILMORE ST., JACQUETTA JENIFER BALTO. MO. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Methed of Disposition 1 Burial 2 Cremation 3 Removal from State GARRISON FOREST 12.6.99 OWINGS MILLS, MO 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Segion Licensee 23a. Part1. Enter the resease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart them. Elist only one ceuse on each line. 21229 **Physician** /Medical Immediate Cause (Final · cardiac brady arythmia due to coronary heart disease disease or condition resulting in death) Examiner Examiner negative senticemia The law requires that the death cartificate be axecuted physician and the burial-trans Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that inflieted events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 mellet Dubetes m Due to (or as a conseque Physician/Medical for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the a signed by t 39 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were eutopsy findings evailable prior to completion of ceuse of death? 24a. Was en eutopsy occlusive arteral disease paga 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes cartificata Aftar this cartifical funeral director, I or Attending Physician: 25. Was case referred to medicel examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 10 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 TYes 2 No daath. 2 ☐ Accident investigation Director: A 6 Could not be determined 3 Suicide To the Hospital or Atterwithin 24 hours after dai To the Funeral Directo completally filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide Y⊆Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and menner es stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29d, Date signed (Month, Dav. Year) 29b. Signature and the of certifier 29c. License number 1995 NOV , 79. 11832

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1999 32. Registrat's Signature

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31. Date filed (Month, 1947,

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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 0931 AM YERT RUDE DOLA ANNA JAMES November 28 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GENERAL HOSPITAL HALFOND FALLSTON FALLSTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 29, 19 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F 216-16-0714 1922 Maryland Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore City MD N/A 1 X Yes 2 □ No Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? b 21201 1 West Conway Street United States 'natural', or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Meritel Status Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: Specify: þ White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be III.
Department of Health and Mental Hy
Important: If Nem 27 is marked oth
any injury or other traumatic even Be Harry Addicks 2 Anna C. Burmeister 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Raietionship (Type, Print) 482 N. Pine Meadow Dr. DeBary, FL Dawn K. Swift (Granddaughter) 20b. Plece of Disposition (Nama of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Meadowridge Memorial Pk. 12/2/99 Elkridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Leonard J. Ruck, Inc. 21. Signeture of Funerel Service Licensee Milton J/ Knight Jr. 5305 Harford Road Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or haart failura. East only one cause on aech lina. Approximete Intervat Between Onset end Death **Physician** /Medical Immediate Cause (Finel ASCUD diseasa or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): attending pt Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Š 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed HYPOTHYROIDINM Addisms Dismo 1 Yes 2 Ho Division of Vital 25. Wes case refarred to medical examiner? or Attending Physician: Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Nes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No death. Investigetion 2 Accident 24 hours after deat Funeral Director: 6 Could not be datarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. completely 2 Medical Examinar: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. (Check only one) within 2 å 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME NOV 28 1994 DME 30. Neme end addrass of person who completed cause of death (Item 23a) (Type, Print) MD 21014 410879-6564 4PRABHO-MD 218 Fulford BELANK AJE 32. Registrar's Signature Registrar

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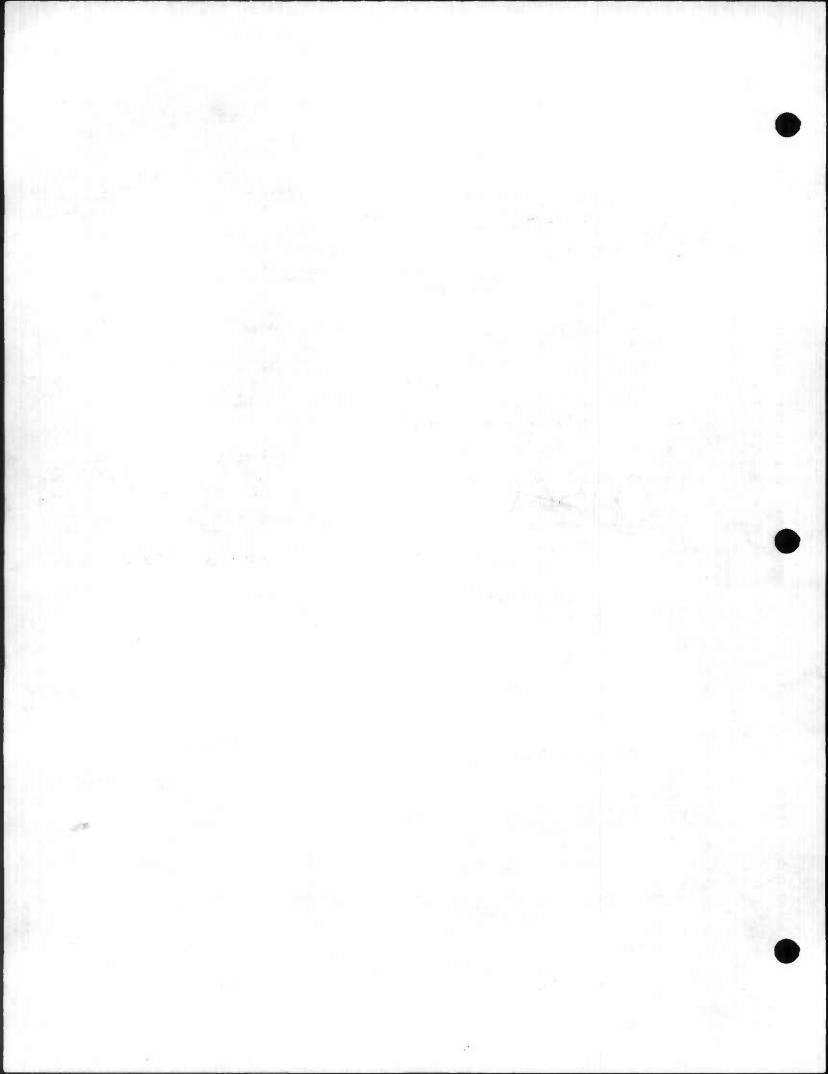
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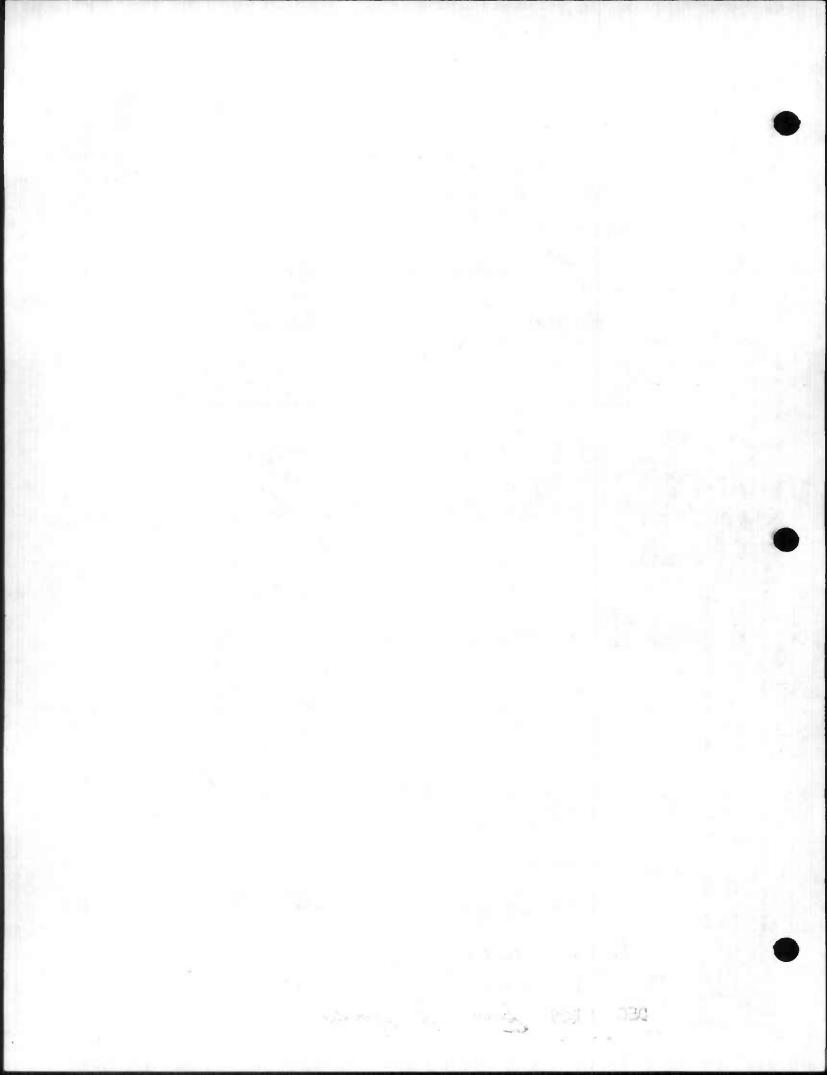
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vital Pricion: The certificate rector, pag	25. Was casa rafarred to medical				26 Place of De	ath (Check only one	9	10 2010	
	axaminar?	Hospital: 1 ☐ Inpatient 20	☐ ER/Outpatien	3 DOA O	har	lome A Residen		ecity)	
g Physical distriction	27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury		ry at ork?	28d. Describe how			
Attending or death. ctor: After by the fune liftcation	Natural 5 Pending invastigation	on .	injury		Yes 2 No				
DIVISION C ball or Attending P is after death. In Director: After t ed in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not lead to determine d	28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,					
Hospi 14 hour Funer tely fill	29a. Certifiar Check only one) Condition Condi	hyalcian: To the best of my kr miner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the trastigation, in my	ima, data and place opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and mannar a a and place, and du	s stated. e to the cause(s)	
within 2 To the comple	29b. Signature and titla of certifiar			29c. Licen	se number	29	d. Date signed (Mon	th, Day, Year)	
	malu	0		NY	2595		Non 1	1999	
9	30. Nama and addrass of person who	completed causa of death (Ite	om 23a) (Type, I	Print)	1313			1	
,	J. Hue Mer 15	18 Sulphur	Sain	Rd	Arbutes	SMD 213	127		
State	31. Data filed (Month, Day, Year)	32. Flegistrar's Sign	nature 9.	Spork	1				



1. Decedent's Name (Fir		ART I,		PER Certi			2. Dete of Do		-	3. Time of Death
MARC	GARET		R.	KI	NG		NOVEMB			5:11P.M.
4a Facility Name (If not			er)			4b. City, Town, or				
JOHNS HOPK: 5. Social Security Number			Ane (In vrs	last birthday)	If Under 1 Year	BALTIM If Under 24 Hrs.		N/i		a (State or Foreign
218-62-29		OM 2₽F	45		Months Days		lts. 8. Date of Birth (Month, Dey, Year) 9. Birthplac Country, JAN . 08 , 1954 MARYI			ca (Stete or Foreig
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
			106, 61							l. Inside City Limit X1 ☐ Yes 2 ☐ N
MARYLAND 10e. Street and Number	N/A			BALTI	MORE 10f. Zip Code			10g. Citizen of	Whet Country	7
2342 BAF	RCLAY	STREET			2	1218		U.S.Z	A	
11. Marital Status 1)(1) Never Married 3 Widowed 4 1	12. Was Decede Armed Force 1 ☐ Yes 2[If Yes, GiveX Year or Date:	is? If Yes, specify Cuban, Mexican, Puerto Rican, etc □ No 1 □ Yes 2 □ No Specify:				pecify Yas or N o Rican, etc.)	s or No- 14. Rece - American Indian, Bleck, White, etc. Space, RO - AMERIC			
15. (Decedent's Ed	ucation	•	16a. Deceder	nt's Usual Occu	pation		16b. Kind of B	lusiness/Indu	stry
(Specify or Elementary/Secondary	de completed) (Give kind of work done diffe. DO NOT use retired			e during most of wor ed)	rking					
12TH 17. Father's Name (First,		CI		CUSTODIAN				RIVATE BUSINES		
LLOYD	KING					HALL	s, maiden surner	Maiden Surneme)		
19a. Informant's Name/F							per, City or Town	, State, Zip C	State, Zip Code)	
TONY KIN	NG /	SON		2342	BARCL	AY ST.	BALTO,	MD. 23	1218	
20a. Method of Disposition		Domoval from Sta		Place of Disposit cemetery, crema	tion (Name of ntory or other pla	ace) DEC	.2,199	20c. Location	- City or Town	n, Stete
4 Donation 5			V	OSHELL	MEMOR	IAL GAR	DÉNS	BALTO	MD.	
shock, or heart feile	una Liet only c		sed the date	th. Do not enter	the mode of dy	ring, such es cardia	or respiretory	arrest,	J-MD-A	21213 oproximete
Immediate Cause (Finel disease or condition resulting in death)			CUTE		CHOPNE	PRESTON ing, such es cardiac	STREE:	I BALT	A A I I	21213 pproximate trerval Between Inset end Death
disease or condition resulting in death) Sequentially list condition	ns C		CUTE Due to (BRONG	CHOPNE ence of):		STREE or respiretory	arrest,	MID	21213 oproximate thervall Between hiset end Death
disease or condition resulting in death)	ons, iate		Due to (c	BRONC or as a conseque	CHOPNE ence of):		STREE or respiretory	arrest,	MID	21213 oproximate interval Between hiset and Death
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disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ons, iate	b	Due to (c	BRONC or as a conseque or es a conseque or es a conseque	CHOPNE ence of):	UMONIA	23b. Dio 1	I tobacco usa co	ontributa to ti	he cause of death
disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant	conditions co	b	Due to (c	BRONC or as a conseque or es a conseque or es a conseque	CHOPNE ence of):	UMONIA	23b. Did 1 = 24a. We-peri	I tobacco usa co Yes 2 □ No s an eutopsy	ontributa to ti	he cause of deat bly 4 Unknot a autopsy finding able prior to oletion of cause ath?
disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant 25. Was case referred to examiner?	conditions co	b c d	Due to (c	BRONC or as a conseque or es a conseque sulting in the und	CHOPNE ence of): ence of): lerlying cause g	UMONIA iven in Part I. 26. Place of De-	23b. Dio	I tobacco usa co I Yes 2 No s an eutopsy ormed? Yes 2 No one)	24b. Were avail comported to the	he cause of dear bly 4 Unknot e autopsy finding able prior to oletion of cause ath?
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disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant 25. Was case referred to examiner? 12 Napher of Death 12 Natural 2 Accident	conditions co	b c d Hospital: 1 Inpe 28a. Dete of Ir (Month, I	Due to (c	BRONC or as a conseque or es a conseque sulting in the und ER/Outpetient 28b. Time of Injury ome, ferm, stree	CHOPNE ance of):	UMONIA iven in Part I. 26. Place of Decther: 4 Nursing Hury at ork? Yes 2 No	23b. Did 1 24a. We peri 24a. We peri ath (Check only flome 5 Res 28d. Describe	I tobacco usa co I Yes 2 □ No s an eutopsy ormed? Yes 2 □ No one)	24b. Were avail comported	he cause of death bly 4 2 Unknown a autopsy finding able prior to oletion of cause ath? Yes 2 \sum No
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disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant 25. Was case referred to examiner? 1X Yes 2 No 27. Manner of Death 2 Natural 5 2 Accident 3 Suicide 6 4 Homicide	o medical Pending investigation Could not be determined Certifying Phys Medical Exami	b	Due to (c Due to (c	BRONC or as a conseque or es a conseque or es a conseque sulting in the und ER/Outpatient 28b. Time of Injury ome, ferm, stree by)	CHOPNE ance of):	iven in Part I. 26. Place of Decther: 4 Nursing Hury at ork? Yes 2 No	23b. Did 1 24a. We peri	I tobacco usa co	24b. Were avail composed to the senser estate and due to the senser estate entre entre estate entre entre estate entre estate entre ent	he cause of death bly 4 Unkno e autopsy findings able prior to oletion of cause ath? Yes 2 No Route Number, ed. he cause(s)
disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other aignificant 25. Was case referred to examiner? 1 [X] Yes 2 No 27. Manner of Death 1 [X] Natural 5 [2 Accident 3 Suicide 6 [4 Homicide] 29a. Certifier (Check only 2 [X] Inne)	o medical Pending investigation Could not be determined Certifying Phys Medical Exami	b	Due to (c Due to (c	BRONC or as a conseque or es a conseque or es a conseque sulting in the und ER/Outpatient 28b. Time of Injury ome, ferm, stree by)	CHOPNE ance of):	UMONIA iven in Part I. 26. Place of Dether: 4 Nursing Fury at ork? Yes 2 No ime, date and place opinion, death occurrence.	23b. Did 1 24a. We peri	I tobacco usa co	24b. Were avail comported their (Specify) pred	he cause of death bly 4 Unknow e autopsy findings able prior to oletion of cause ath? Yes 2 No Route Number, ed. he cause(s)

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 37605 Certificate of Death

	Physic /Medi Examii	cal
	Funeral Director	
-	12	•

To Be Completed by Funeral Directo Baltimore, Maryland 21215-0020 Physician Examiner Division of Vital Records, P.O. Box 68760, To the Hospital or Attending . Name and address of person who completed cause of death (Item 23a) (Type, Print) MALCOLM BROCK

1. Decedent's Name (First, Middle, La	ist)		6					2. Date of Do		1.0) Šear	3. Time of Death
GEORGE		V = 1	KMIE	CIAK		45 63 -						01:02
4a Facility Name (If not institution, given THE JOHNS HOPKI)		,				BALTI	MOR		th 4c. (County	of Death	
5. Social Security Number 6. S 218-18-7827	Sex 7 1 M 2 □ F	. Age (In yrs. 74	last birthda Yrs.	Monti	der 1 Yea hs Days		24 Hrs. Min.	U. Date of Di	rth ay, Year) 2 192	25	9. Birthe Cour Md .	place (State or Foreign htry)
Usual Residence of Decedent											· ·	
Md. Baltime	ore	10c. Cit	y, Town or Dun	Location dalk							1	0d. Inside City Limits 1 ☐ Yes 2 X No
10e. Street and Number					Zip Code				10a Citis	on of b	Vhat Cour	Mar?
6603 Maple Ave	e.			101.	212				US		Vilat Coul	nyr
1. Marital Status 1 Never Married 2X Married	12. Was Deced Armed Ford 1. Yes 2 If Yes, Give	es?	,S. 1:			Hispanic Ori ban, Mexicar		pecify Yes or No o Rican, etc.)		Blac	k, White,	
3 Widowed 4 Divorced	Year or Dat	es:								Specify		ite
15. Decedent's En (Specify only highest gra			16a. Dec	ve kind of	work don	upation e <i>during mos</i> ed)	t of wor	rking	16b. Kin	d of Bu	usiness/In	dustry
Elementary/Secondary (0-12) 8 VYS.	College (1-	lor 5+)	Inte		_	90)			Cor	rec	rtio	nal offi
17. Father's Name (First, Middle, Last)			Gua	Lu	18 Moth	r'e Ner	ne (First, Middle				THE CITT
	eciak							vieve				i
			T 481 11									
19a. Informant's Name/Relationship (ural Route Numb				Code)
Frances Kmiec	ıak W	ife			-	e Ave	. D	undalk				0
20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ate	Place of Dis cometery, c tro	rematory o	or other pl			ov.30			City or To	own, State
1. Signathro of Funeral Service Licer		6		22. Name	and Add	ress of Facilit	v	1999				
> Howe !	me	SI		Conn	elly	Fune	era	l Home				k
23a Fant: Finer the disease, or com- about or heart failure. List only Immediate Cause (Final disease or condition		ARDIOGI					cardiad	c or respiratory a	arrest,			Approximate Interval Between Onset and Death
resulting in death)			ras a cons			211					1	FOUR HOURS
	. 15	CHEMIC	HEAR	T DT	SEASI	7						24 HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D	-	r as a cons								1	24 HOURS
Cause (Disease or injury that initiated events	c	S t. t.										
resulting in death) Last	d	Due to (o	r as a cons	equence o	ot):							
			44 1 4					1				
Part II. Other significant conditions o	contributing to dea	th but not res	ulting in the	underlyin	g cause g	iven in Part I	•		Yee 2			the cause of death
								24a. Was	s an autopomed?	sy	av	ere autopsy findings ailable prior to impletion of cause death?
								10	Yes 2	0 No	1[JYes 2ŽNo
25. Was case referred to medical examiner?							of Dea	ath (Check only	one)			
1 Yes 2 No	Hospital: 1 🗷 Inj	patient 2	ER/Outpat	ient 3	DUA		ırsing H	lome 5□ Res	idence 8	Oth	er (Specil	(y)
7. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month)	Injury Day Year)	28b. Time Injury		28c. lnj W	uryat ork?]Yes 2[]	28d. Describe how injury occurred					
3 Suicide 6 Could not be determined	e 28e. Place o	f Injury - At h	ome, farm,	street, fac	tory, office	28f. Location (Street and Number or Rural Route Num. City or Town, State)			al Route Number,			
29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	nysician: To the best and manner	is of exa <i>m</i> ina	wiedge, de tion and/or	ath occurr investigat	ed at the ion, in my	time, date an opinion, dea	d place th occu	e, and due to the arred at the time	cause(s) , date and	and ma place,	anner as s end due to	itated. o the cause(s)

State Registrar

31. Date filed (Month, Day, Year)

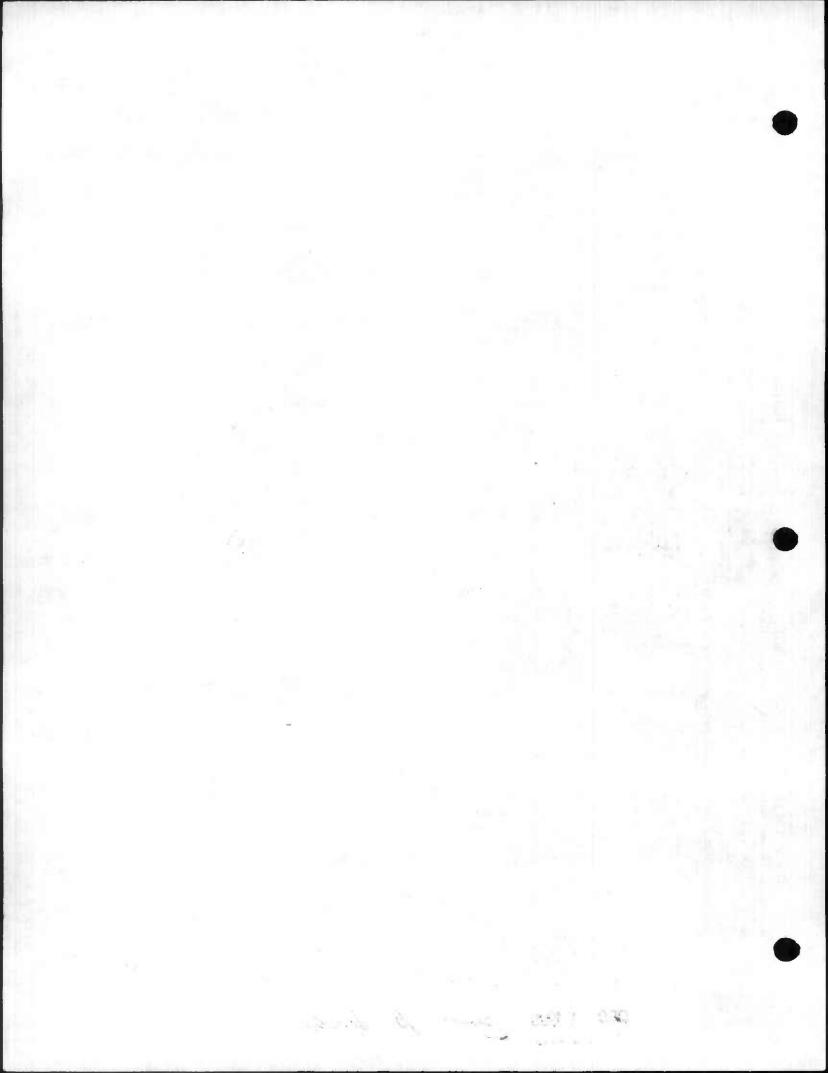
600 NORTH WOLFE STREET

RES 000

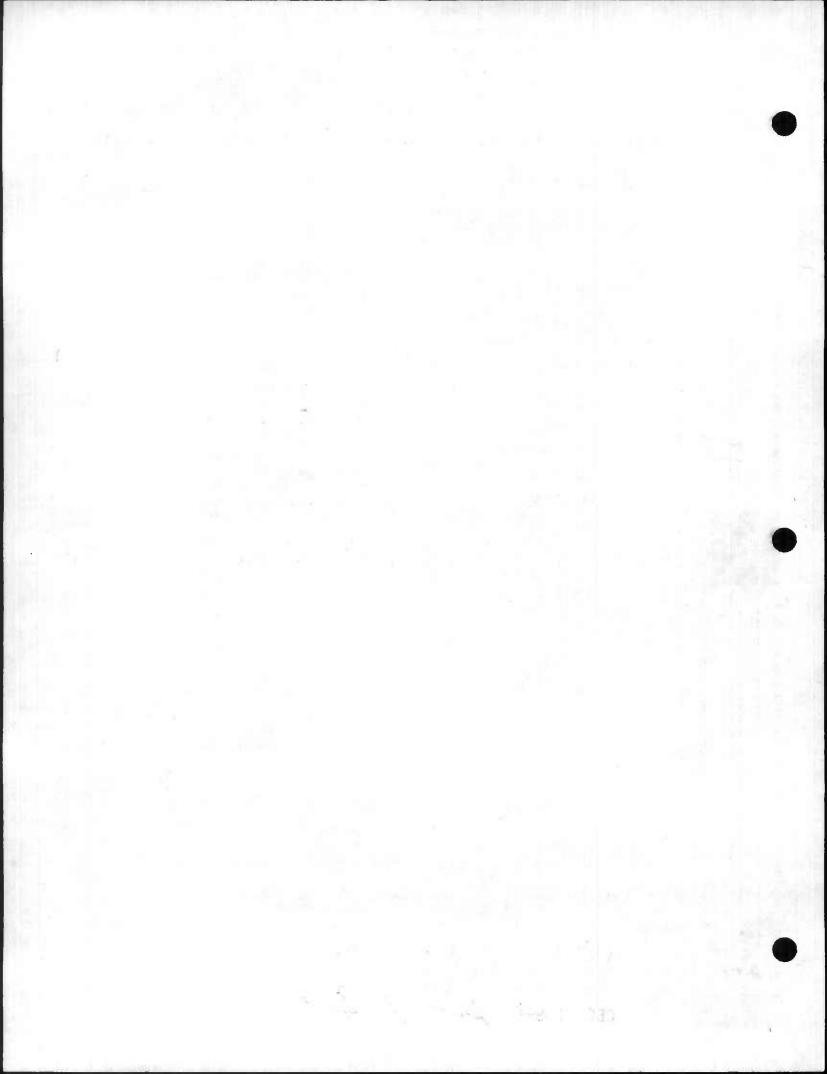
BALTIMORE, MARYLAND 21287

NOVEMBER 30, 1999

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37606 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Physician NICHOLAS W. KALTENBACH, JR. Nov 15:30 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospita Baltimore Baltimore O' 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) s. Sex 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2 F Kalten Gach 220-09-8363 Director 80 June 25, Usual Residence of Deceden 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, the Medical Examinar mast be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Charmuth Rd. 21093 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: ₩₩— I I 14. Race - American Indian. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 □ Never Married 2 N Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White aks known as 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiens. ther then Elementary/Secondary (0-12) College (1-4or 5+) Accounting State of Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 99 permit. Pages 1 and 2 should be Department of Heath and Mental Important: If Item 27 is marked of any Injury or other the should be and Mental Nicholas Kaltenbach Barbara Moorman 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Charmuth Rd. Timonium, Md. 21093 Mrs. Anne K. Kaltenbach/wife 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 12/3/99 Timonium, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Specior Licens 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) 080 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, à 24a. Wes en autopsy parformed? 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed certificate has 1 Yes 2 No 1 Yes Division of Vital 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) il or Attending Pi efter death. Director: After th 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending investigation 1 Tyes 2 No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital or A 24 hours effer Funeral Dire 29e. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. To the To To the To the P 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certified -000 Ycause of death (Item 23a) (Typa, Print) 2+1 BALTIMORE, MD 2121 CHONG T. HA W. BELVEDERE AVE 2401 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State porks 1999 DEC Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KOEPPEL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month

29.

November

4b. City, Town, or Location of Death

1999

29d. Dete signed (Month, Day, Year)

4c. County of Deeth

9:30 AM

Physician /Medical Examiner

ROBERT

4a Facility Neme (If not institution, give street and number)

Funeral

Director

Funeral

Director show "natural", or lients 23a or 28a-f show edical Examiner must be notified at Hygiene.

filed within 72 hours after

Examiner physician and s the burial-transit 3 signed b peeu certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

altimore, Maryland 21215-0020 à Completed poemit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important. If then 27 is restricted other that any Injury or other transmission. Be George **Physician** /Medical Examiner Box 68760 Physician/Medical P.O. þ Records, Completed Division of Vital Be Certification: To 3 Suicide 4 ☐ Homicide 29e. Certifier Medical (Check only one)

Baltimore Blakehurst Care Center Towson 8. Data of Birth (Month, Day, Year) 6. 1916 If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Yrs 83 N.Y. 119-10-9760 Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21204 USA 1055 W. Joppa Rd. Apt. 512 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 Nes 2 No If Yes, Give Specify: White 1 Yes 2 No Specify: 3 Midowed 4 Divorced Year or Dates: WW-II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) **CPA** Haskins & Sells 12 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Koeppel Neugebauer Frederick Theresa 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurat Route Number, City or Town, Stata, Zip Code) Mrs. Marilyn K. Ogburn/daughter 9 St. Martins Rd. Baltimore, Md. 21218 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 12/1/99 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. Towson, MD. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. of Funeral Service Licens 1050 York Rd. Towson, Md. 21204 Approximate Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 → Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to complation of cause of death? 24a. Was an autopsy Aton Dissole 1 Yes 2 No 1 Yes 2 No 25. Was case reterred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Natural 5 Pending 1 TYes 2 □ No investigation 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, tactory, office building, atc. (Specify)

DHMH 16 Rev 6/95

State Registrar

1999

eluns

30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Priot)

29b. Signeture and title of certifies

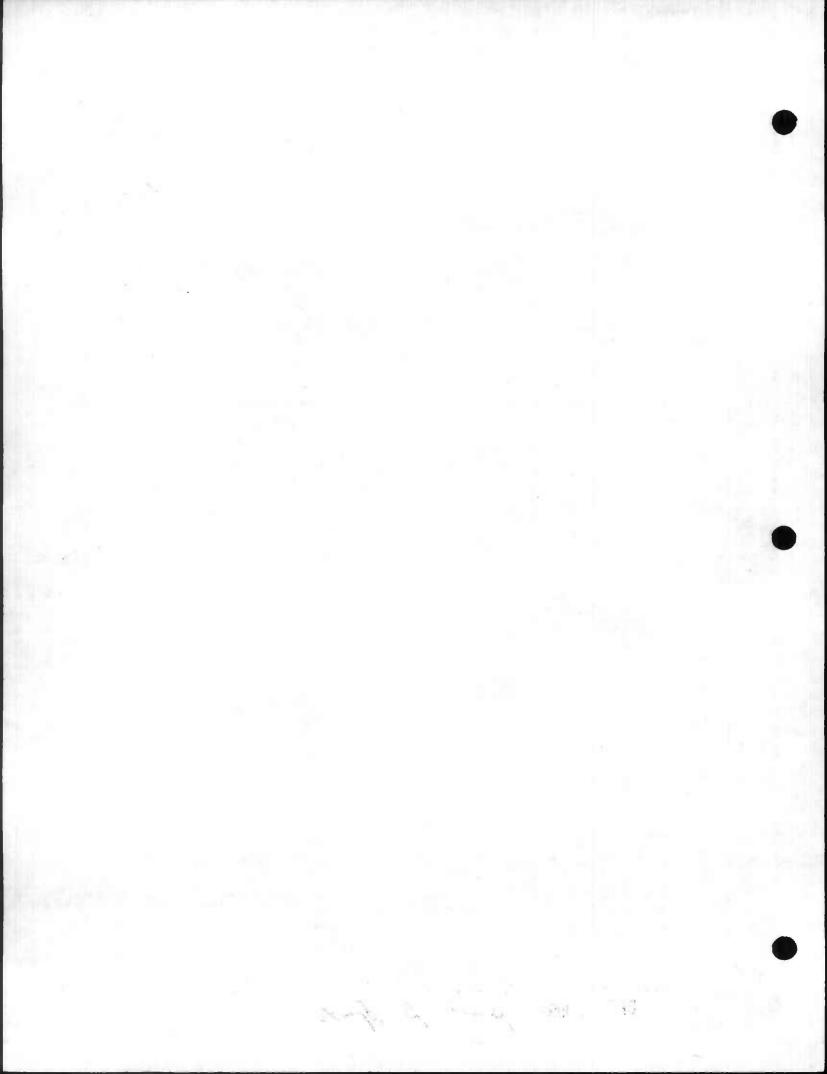
32. Registrer's Signeture

m

1 🖵 Confliging Physician: To the best of my knowledge, deeth occurred et the time, data and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end manner stated.

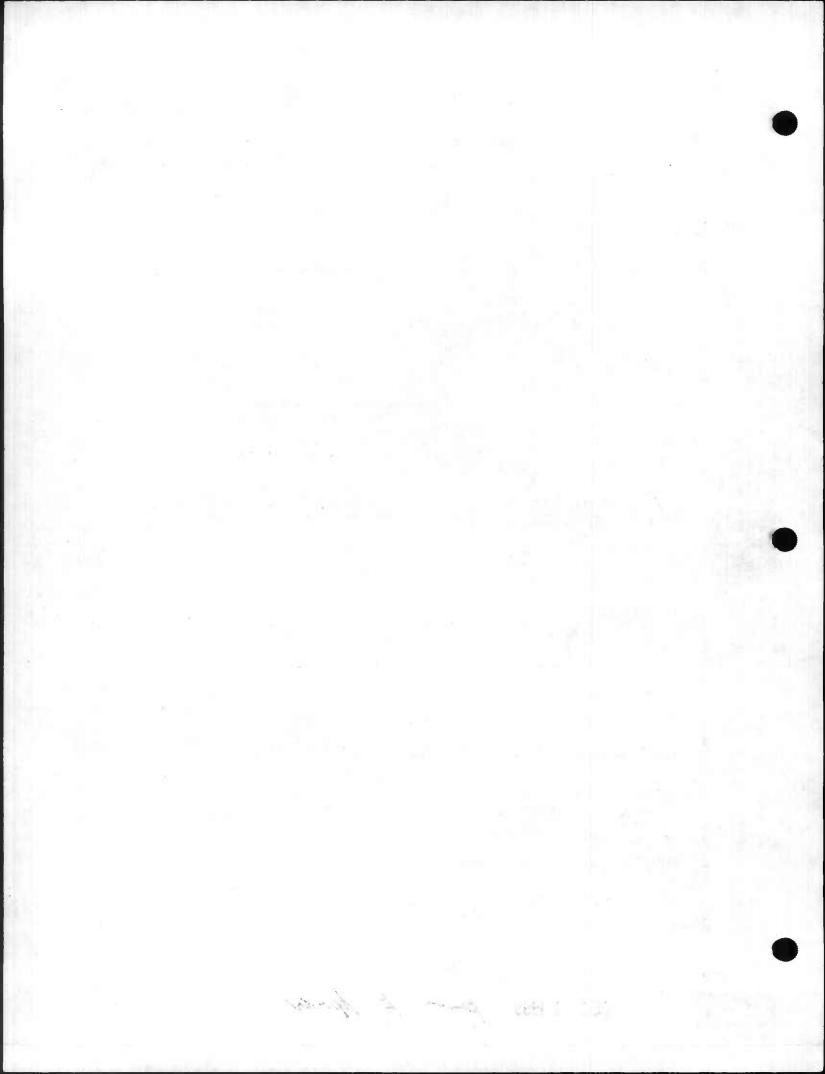
29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	A CONTRACTOR OF THE PARTY OF TH	Certificate of Death	Reg. No. 99 3/608				
Physician	Decedent's Name (First, Middle, Last)		Date of Death Month Day Year 3. Time of Death				
/Medical	CECELIA KELLY		(ovember 29, 1999 10: 21 AM				
Examiner	4a Facility Name (If not institution, give street end number)	4b. City, Town, or Local	4				
	FRANKLIN Square Hospita 5. Social Security Number D 6. Sex 7. Ade (In vrs		Dete of Birth 9. Birthplace (Stele or Foreign				
Funeral Director		Months Days Hours Min. M	Date of Birth (Month, Day, Year) 1931 9. Birthplace (State or Foreign Country) West Virginia				
Pu & m		ity, Town or Location	10d. tnside City Limits				
with the Maryland a or 28a-f show be notified at	Md Baltimore	Middle River	1 ☐ Yes 2 🕱 No				
deeth with it	3733 Chestnut Road	10f. Zip Code 21.220	10g. Citizen of What Country? USA				
020 urs after alf, or the	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- zan, etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
- c - 3 - 5	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry				
Aaryland 2121 2 should be filed within and Mentel hygiene. Is marked other than " currents event, the law To Be Comple	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	own home				
and 2 be filed dother event, H	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Surname)				
should be nd Mentel marked o umarke eve	John Streafas	Gold	lie Blakmakis				
Maryland d 2 should be file th and Mentel Hy 7 ie marked oth treumatic event	19a. tnformant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural F					
	Charles E. Kelly /husband 20a. Method of Disposition 20b.		Baltimore Md. 21220 Date 20c. Location - City or Town, State				
0 8 2 7 7	I ALI DURAL 2 LI Cremation 3 Linemoval from State	Place of Disposition (Name of cemetery, cremetory or other place) Olly Hill Cemetery 12/2/					
Baltimoperant: Pag Department Important: I any injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Connelly Funeral H 300 Mace Ave. Balt					
U	23a. Pert1. Enter the disease, or complications that caused the descendence of the descen	th. Do not enter the mode of dying, such as cardiac or n	espiratory arrest, Approximate Interval Between				
Physician /Medical	tmmediate Cause (Finat		Onset and Death				
Examiner	disease or condition a. HVPDXQ	mia	3 hours				
i i	Due to (or as a consequence of):	121-				
executed in end rial-transit	Sequentially list conditions.	or as a consequence of):	says				
60, be exacuted leien end burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ive Heart Failure	3 days				
68760, ficate be en physician is the buria	resulting in death) Last	or as a consequence of):					
Box 6 listh certific attending p for use as	. Reval	insufficiency	6 months				
Box dasth cert attendin d for use	Part II. Other significant conditions contributing to death but not res	pulting in the underhing gauge nives in Part !	23b. Did tobacco use contribute to the cause of death?				
igned by the absolute be detached for by Physic			1 Yes 20 No 3 Probably 4 Unknown				
s the se the be de be de	Atrial FIBRICIATION, AC	ortic and mitral					
SCOrces to the second s	valve disease, Type	. Two Diabetes	24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?				
			1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No				
raician: The yaician: The yaician: The yaician: The yaician of the yaician of the yaician of yaicia	25. Was case referred to medical examiner?	26. Place of Death (Check only one)				
of hyale			5 ☐ Residence 6 ☐ Other (Specify)				
After fune	1 Maturel 5 Pending (Month, Day Year)	Injury Work?	d. Describe how injury occurred				
Division of Vita and or Attending Physician: after death. Director: After this certific in by the funeral director, in by the funeral director, extification: To Be (extification: To Be (extification: To Be (extification)).	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or I						
Div altor din to	4 Homicide building, etc. (Special	(4)	City or Town, State)				
Division o To the Hospital or Attanding Ph within 24 hours after death completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known one) 1 Certifying Physician: To the best of my known one of the basis of examiner and manner stated.	owledge, death occurred at the time, date and place, and attended on and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. et the time, date and place, and due to the cause(s)				
To the complex complex Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
d	Trosper/ Nys	D H0054913	November 29, 1999				
1.8	30. Name and address of person who completed cause of death (Item	m 23a) (Type, Print)					
W.	PROSPER Sanchez M.D. 9000	Franklin Square Drive	Baltimore Maryland 21237				
State Registrar	30. Name and address of person who completed cause of death (Item PROSPER SANCHEZ M.D. 9000 31. Date filed (Month, Day, Year) 1 199932. Registre's Sign	De sports					

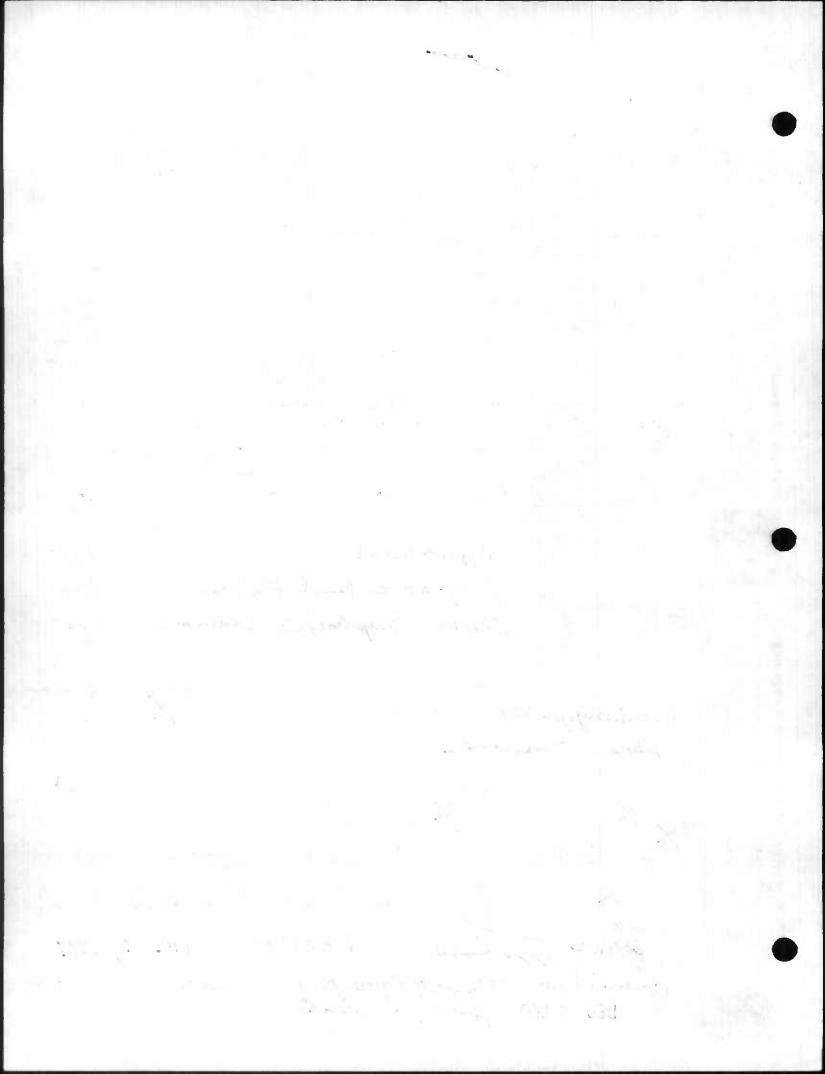


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State of Maryland / Dep	artment of Health and	Mental Hygiene	Q I	9	37	51	7	7	
Co	rtificate of Death		1	2	UI	0	<i>U</i> .		

					Ce	rtificate o	f Deat	h	B	eg. No.	2	1003
100	Physician	1. Decedent's Name (First, M.							2. Date of Deal Month	th Day	Year	3. Tima of Death
	/Medical	Jerry J.	Lee	Table 1			45 (26.	Faura and	NOV.		9	2:50am
	Examiner	4a Facility Nama (If not institu Good Samar	itan Hosp	ital			Ва	ltim	ore	1	y of Death	
	Funeral Director	5. Social Security Number 219-38-5185		7. Age (In yrs. Ia 58	est birthday) Yrs.	Months Day		er 24 Hrs. Min.	8. Data of Birth (Month, Day) 06-02	Year) 2-41	9. Birth, Cour	place (State or Foreign ntry) MD
pue	š =	Usual Rasidance of Decedent 10a. Stata 10b. Cou		10c. City,	, Town or Lo	ocation					. 11	10d. Inside City Limits
the Maryland	28a-f show notified at	MD	NA	Ba	ltimo	ore						TXYes 2□No
death with th	r items 23s or 28s-f sincer must be notited Funeral Director	10e. Street and Number 6510 Walthe	r Avenue			10f. Zip Code 212			1	0g. Citizen of USA		ntry?
- je	by by	11. Marital Status 1 Nevar Married 20 N 3 Widowed 4 Divor	Armed For	XIXNo		Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☐ N			ecify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White, by: Bla	
21215-0020	ygiene. or than "naturel", f. or we done Completed by	15. Dece (Specify only his	dant's Education hast grada completed)		(Giva	dent's Usual Occ	ne during m	ost of work	ing	16b. Kind of E		
2121 within	r than	Elemantary/Secondary (0-1	2) College (1-4or 5+)	Cler	DO NOT use ret ^ k	ired)			Socia	al Se	curity
×	d other event, n Be Co	17. Fathar's Name (First, Mide					18. Mol	her's Nem	a (First, Middle, I			
ylai ould b	marked matic ev	Carroll	J. L	ee			Re	gina	R. 5	St. Ro	ose	
Maryland	9 6 9	19a. Informent's Name/Relati		h								Code) 21218
č	frem 27 other tr	Jerreldon 20a. Mathod of Disposition	L. Stines	20b Pla	ce of Dispo	osition (Name of		enue	Baltir	20c. Location		
im Pag		1 ☐ Buriai 2 ☐ Crematic 4 ☐ Donation 5 ☐ Othan		Stata K	ings	Mem. E	ok. C	1				lstown, MD
Balt pemit.	Department of Important: If eny injury or once.	21. Signatura of Funeral Serv	ce Licensee			2. Nama and Add			Baltimo 1101 E.		-	and 21202
		23a. Part1. Enter the disease shock, or heart feilure.	, or complications that o	aused tha death.							ì	Approximata Interval Between
	nysician		ast only one decad on t	11	-	1						Onset and Death
	Medical kaminer	Immediata Ceuse (Final disaase or condition rasulting in death)	a	Hyper.	tens	in					1	lyr
	Je L				as a consec		1	F	1		t i	140
cuted	physician and s the burial-transit	Sequentially list conditions,	6.	Dueno (or	as a consec	quence of):	acc	ra	lenke		t t	171
60,		Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or injury		homic	6	ymphi	cyti	C	Centre	mia		lyr
ox 68760,		that initiated evants rasulting in death) Last		Dua to (or	as a conseq	quence of):						. /
X	use a		d									
. 8	the att	Part II. Other algnificant cond	Itlons contributing to de	eath but not rasult	ting in the u	nderlying causa	given in Pa	t I.	23b. Did to	obacco use co	ontribute t	to the cause of death?
P.O.	ate has been signed by the attendin , page 2 should be detached for use Completed by Physician/N	Cardiony	espathy						1 🗆 Y	es 2 No	3 Pro	obably 4 Unknown
of Vital Records, Physician: The law requires t	od by	10-0	20						24a. Wes a			/ere autopsy findings
eco law re	2 sho	penal	Jane	me_					perfor	med?	CC	vailable prior to empletion of cause death?
H H	certificate has rector, page 2 Be Comp								1 🗆 Y	85 20 No	11	□Yes 20 No
of Vita Physician:	Be Be	25. Was casa rafarrad to med axaminar?						ce of Deal	th (Check only on	10)		
	0.0	1 Yas 20 No	Hospitel: 1 28a. Data		R/Outpatier 28b. Time of	NE 3LI DOA		Nursing Ho	oma 5 Reside		-	fy)
Vision	th. : After e fune atlon	1 Netural 5 Per		th, Day Year)	Injury	V	Vork? ☐ Yes 2	□No	200. 2000 100 11	ow injury cood		
Division for Attending	within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	3 ☐ Suicida 6 ☐ Cou		of Injury - At horn ng, etc. (Specify)		reet, factory, office	08		28f. Location (SI City or Town	treet and Num n, Stata)	ber or Run	al Routa Number,
piter o	filled in Ce	29a. Certifier Certif	ying Physician: To the	best of my know	ledge, death	h occurred at the	time date	and place	and due to the c	ause(s) and m	anner as s	stated
To the Hospitar	within 24 hours To the Funerel completely filled		al Examiner: On the be	asis of axaminetic	on and/or in	vestigation, in m	y opinion, d	eath occur	red at the time, d	ata end place	, and due t	o the cause(s)
Tot	To the	29b. Signature and titla of cert	ifier	/		29c. Lice	ense numbe	07	2	9d. Data sign	ed (Month,	Day, Year)
		Jujun	m			D	409	0+		DEC	1,	1999
1		30. Name and addrass of pers	on who complated caus	a of death (Item :	. 10	Print)	01.1	,	2 /6			2/12/
	State	31. Data filled (Month Day, Ye	(im J ar) 32. A	egistar's Signatu		aven	SIVE	/ - F	Bultimo	e /	(1)	21254
ĮII.	Registrar	DEC	1 1999	Denews	1	D DO	als					

DHMH 16 Rev 6/9

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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DOMENTCA LANGGOOD NOVEMBER 28, 1999 9:05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLONIAL MANOR NURSING HOME SEVERNA PARK ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2√2 F Months 74 NOV. 28, 1925 MARYLAND Director 213-20-7697 Usuel Residence of Decedent 10c. City. Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No 28a-f Directo MARYLAND ANNE ARUNDEL GLEN BURNIE 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? mast be r Funeral 300 AQUAHART ROAD 21060 U.S.A. 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. then "netural", or iten the Medical Examiner Bleck, White, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: py 3√ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Hygiene. filed within Elementery/Secondary (0-12) College (1-4or 5+) 12 TECHNICIAN DEFENSE INDUSTRY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Pages 1 and 2 should be fit traint of Health and Mental H tant: If Nem 27 is marked oth fury or other traumatic even 88 Lo FRED DOMENICA 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PAULA CARE- DAUGHTER 256 TOLSTOY LANE, SEVERNA PARK, MARYLAND 21146 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Melhod of Disposition 20c. Location - City or Town, State Dete 1 Surial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: It any Injury or GLEN HAVEN MEMORIAL PARK! 12/2/99 GLEN BURNIE, MD 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 MANDE 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. Listjonly one cause on eech line. Approximete Onsel and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical OMULISSD. Examiner Due to (or as a consequence of) Examine sinstle The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury 68760. Physician/Medical thet initieted events resulting in death) Lest Due to (or as a consequence of): use as the Box (P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 100 3 Probably 4 Unknown I Insome (a Records. by 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed ebad 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Wes case referred to medical B 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOS PLCE 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Division After 1 DNatural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homlcide To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier edical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 017753 Ja, acobrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ROBERT B. KROOPNICK, M.D., 795 AQUHART ROAD, SUITE 203, GLEN BURNIE, MD. 21061 31. Date filed (Month Day, Year) 32. Registrar's Signature State 1999 Registrar

AH

DEC 1 1999 June & June

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death NOVEMBER 22 **Physician** 1999 8:51PM LITOFSKY MAURICE /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPICE OFBALTIMORE - GILCHRIST CENTER TOWSON BALTIMORE | Hunder 1 Year | Hunder 24 Hrs. | S. Dete of Birth (Month, Day, Year) | SEPT. 3, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 12XM 2□ F Birthplaca (Stete or Foreign Country) **Funeral** Yrs. 88 UKRAINE Director 216-01-2106 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Ineide City Limits or hams 23s or 28s-f show 1 Yes Z No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21208 USA 8300 SCOTTS LEVEL RD. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 XYes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 X Merried WHITE 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 next of Health end Mental Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) UPHOLSTERY 12 OWNER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be REBA MOLOFSKY LITOFSKY ISAAC 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21208 8300 SCOTTS LEVEL RD. FANNY LITOFSKY (WIFE) tant: If Item 27 20b. Pleca of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition 11/24/99 Separtment of Surial 2 ☐ Cremetion 3 ☐ Removel from Stete
4 ☐ Donetion 5 ☐ Other (Specify) MOSES MONTEFIORE WOODMOOR HEBREW BALTIMORE, MD 21. Signeture of Muneral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. BALTIMORE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as e consequence of) Examiner be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 5 8 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 1 Yes 2 No Vital Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To of 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 DNaturel 5 Pending investigation 1 Yes 2 No death. 2 Accident 24 hours after dea Funeral Director 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 6 Hospital 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. edical 29a. Certifier pletely (Check only one) within 2 To the g g 29b. Signeture and little of celliflie 29c. License number , uno November 23, 1989 125205 30. Neme and address of person who completed cause of death (Ijem 23a) (Type, Print) N. Charles St. Balto. md 21205 GRMC 6701 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State DEC 0 1 1999 Registrar sporks

DHMH 16 Rev 6/95

Registrar

29b. Signature and title of certifier

Kennets M. Green, mo

DHMH 16 Rev 6/95

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Attending

1999 Registrar's Signature

6701 N. Charles

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

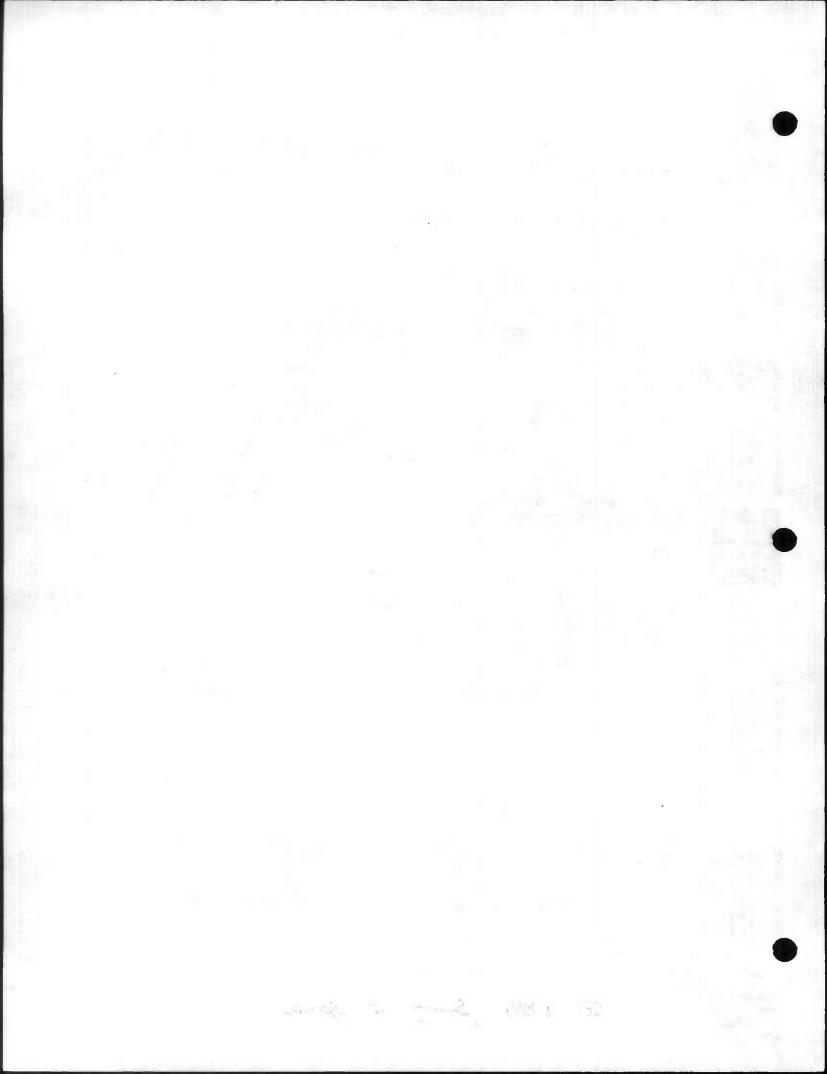
29c. License number

037016

H, Sate 4105 Bilfron, uno 21204

29d. Date signed (Month, Day, Year)

November 29, 1997



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Tima of Death Day Month Year **Physician** Richard LaPorte 8:10 AM November 29, 1999 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A 1138 Newcomb Way If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 F 031-28-1719 Director 61 Oct. 6,1938 Massachusetts **Usual Residence of Decedent** the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1⊠Yes 2□No Director Maryland Baltimore City N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 United States 1138 Newcomb Way Funeral death 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Peges 1 and 2 should be filed within 72 hours effer to not of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Tyes 2 No Specify: by Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Industry Truck Driver 12 Years 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Adelaide Costello Joseph LaPorte (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21205 1138 Newcomb Way Mrs. Caroline A. LaPorte or other 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Pege Department of Important: If any Injury or pace. 12/3/1999 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service License 22. Nama and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. olinery d. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart lailure. List only one cause on each line. Approximata Interval Batween Onset and Deeth **Physician** /Medical Immediata Causa (Final mon diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner physician end s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) 98 for use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobação use contribute to the cause of death? 1 10 100 2 No 3 Probably 4 Unknown Records, p The law requires 24b. Wara eutopsy findings aveilable prior to complation of causa of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No 1 Yas 2 No of Vital or Attending Physician; 25. Was casa refarred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Aesidence 6 Othar (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident the 6 Could not be 28l. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide Hospital 112 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only one) within 2 \$ 29b. Signature and title of certifies 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar 30. Name and add

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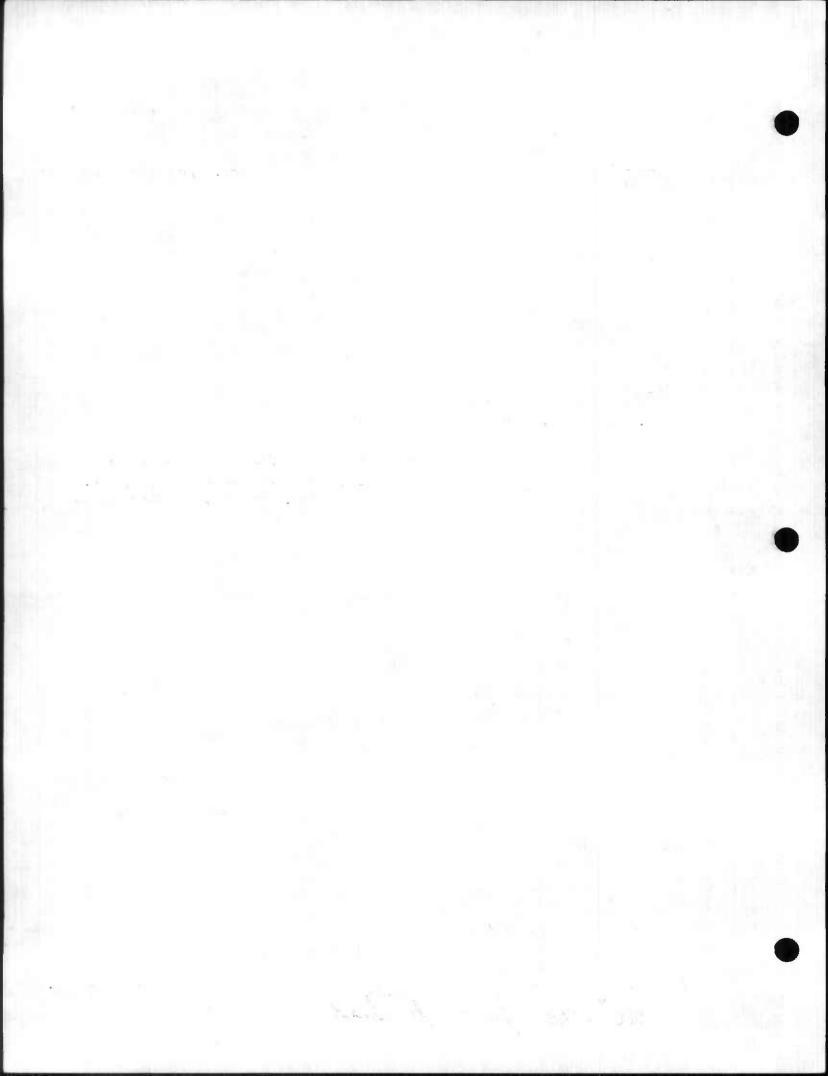
1999

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4940 EASTERN AVE. - A Building Mon 112 Baltimone MD 21224

sen who completed gause of death (Item 23a) (Type, Print)

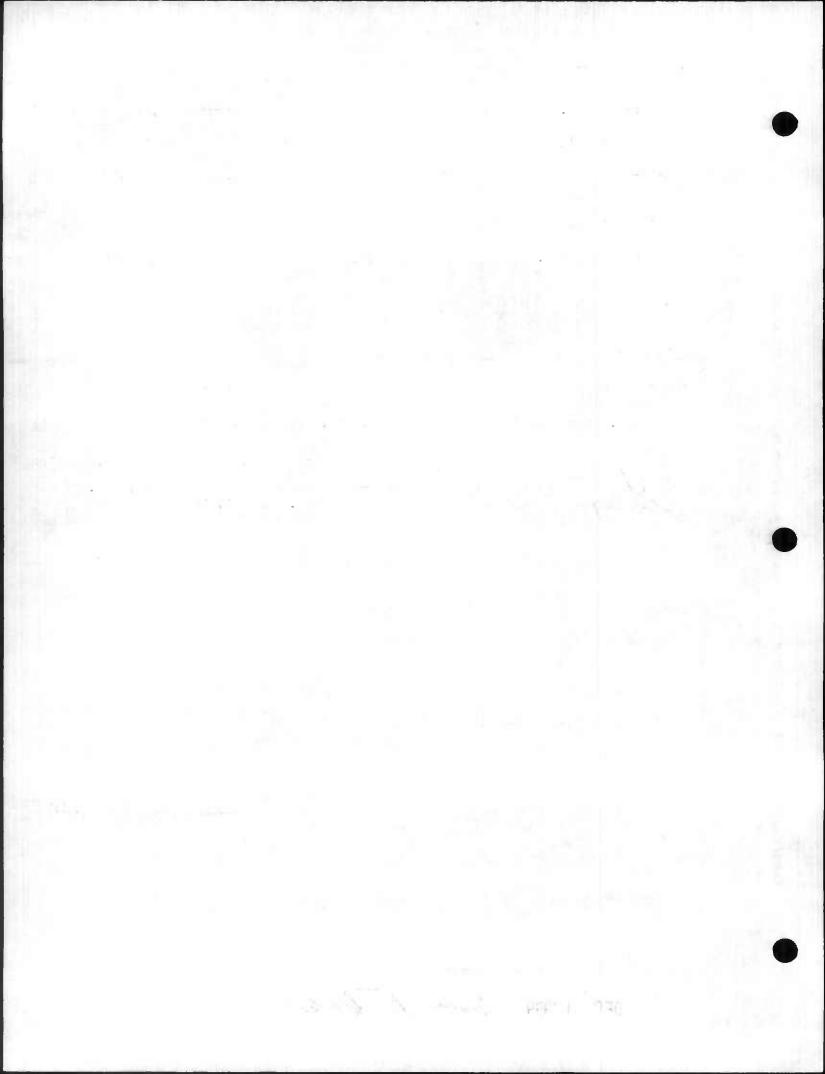
32. Begistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#26 perPhyG778 12/01/99 EW 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Christabel M. Lawrenson 4:45 PM November 26, 1999 cation of Death 4c. County of Death /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death Examiner Gloria Friend's Home ESSEX If Under 24 Hrs. Baltimore If Linder 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 ☐ M 2 ☑ F Yes Director 89 220-74-9026 12/21/1909 Wales Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location ahow 10d. tnside City Limits r than "natural", or hema 23a or 28a-f ahov the Medical Examiner must be nottled at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Edgemere 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 2510 Lakeview Ave. 21219 death Funeral United States 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 220 No If Yes, Give Yeer or Detes: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3℃Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10th Grade Housewife Home 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be Edward Evans Mary Ann Brewer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Neme/Reletionship (Type, Print) Raymond E. Lawrenson (son) 2401 East Ave. Edgemere, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Date 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cemetery 11/29/99 Baltimore, Maryland 21. Signature of Punerel Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland ase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel · CEREBROVASCULAR DISEASE disease or condition resulting in death) Examiner Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) ettending p for use as detached Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown ALTHEIMER'S DEMENTIA Records, Q 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed The law 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Recidence 6 (2)Other (Specify) Certification: To this funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? After 1 Neturel or Attending 5 Pending investigation • 24 hours after death. • Funeral Director: After the function the function the function to th 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) à 4 Homicide Hospital 12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifler edical To the Hosp within 24 hou To the Fune completely fi (Check only 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, D17996 (MD) NOV 27 same 30. Neme and address of person who completed cause of death (ftem 23a) (Type, Print) ZALANO mb 9000 FRANKLIN SQUARE DR BALTO MD 2123) DAUD 32. Registrer's Signature 31. Dete filed (Month Car Year) State books Registrar



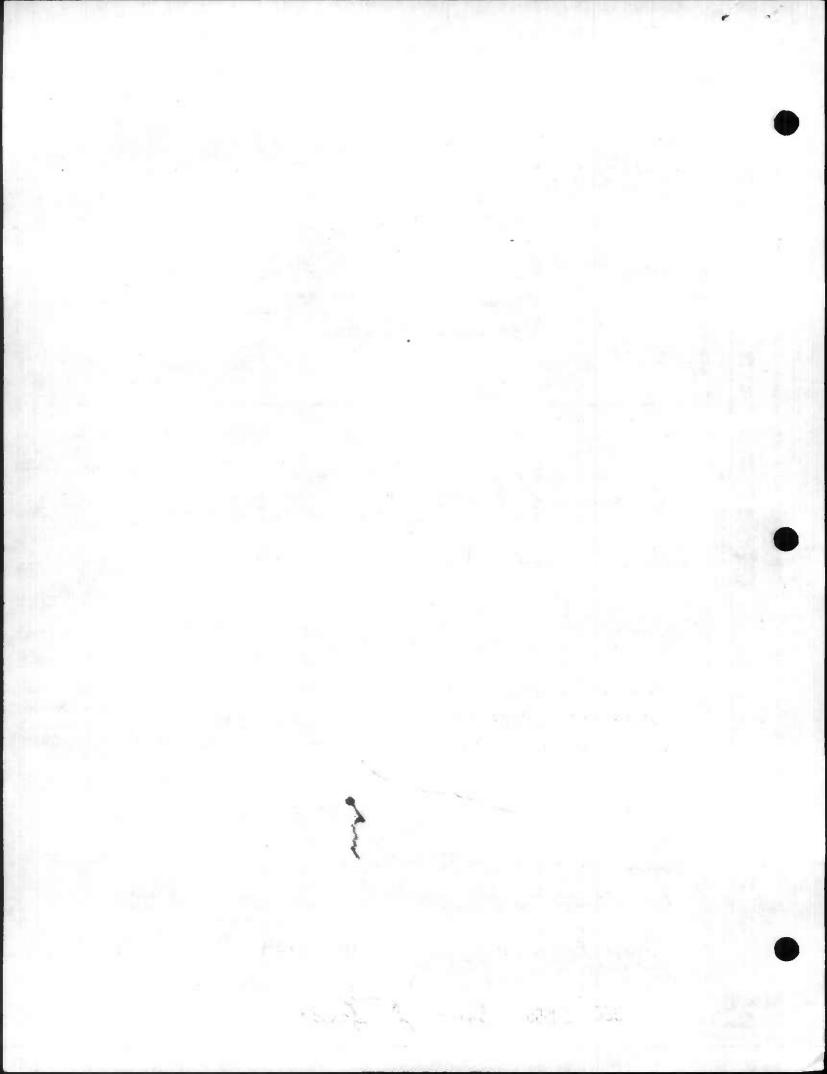
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** NOV. 9 Year 12:15pm 17% Viola /Medical 4s Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Geniatric Center Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 237-24-4675 78 Yes Director NC 01-01-21 Usuet Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show thirty or other traumatic event, the Medical Examiner must be notified as botte. X Yes 2 No Director MD Howard Jessup 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7861 Jones Road 20794 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried aitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Unknown Domestic Pikesville Amory 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Robert Daughtry Rose Purvis 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barber 1102 Druid Hill Avenue Baltimore, MD 21201 20b. Plece of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Buriat 2 Cremetion 3 Removel from Stete MD. Nat'l Mem.PK. Cem. 11-23-99 Laurel , MD 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD. 21202 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility WM. C. March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximate tntervet Between Onset end Deeth **Physician** /Medical Immediate Cause (Finet ulmonary Emboli disease or condition resulting in death) Examiner or Attending Physician: The law requires that the death certificate be asscuted the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of) for use as Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Munknown Hypertension Pulmonary ete has been signed pege 2 should be de Records, þ Completed 24b. Were eutopsy tindings eveilable prior to completion of cause ot deeth? Right Heart Failure 24a. Was en autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Division of Vital After this certification, funeral director, 25. Was case reterred to medical examiner? B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZONO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ QOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Matural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)
nal Novern ber 17 29b. Signature end title of certifier 29c. License number 17,1999 original Mymy Edmond MD D0053124 December 1, 1999 address of purson who completed cause of death (Item 23a) (Type, Print) Hopkins Bayview Circle, Baltimore Maryland 21224 31. Date filed (Month, Day, Year) 32. Registrár's Signature State DEC 1999

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37616 Certificate of Death Antonio D. Mcneal 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** November 27, Antonio Darnell McNeal 1999 17:30 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3500 Cliftmont Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 05-13-78 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□M 2□F 220-98-2308 Yrs 21 Director MD **Usual Residence of Decedent** with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow MD NA X Yes 2 No Baltimore Directo must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 3516 Frankford Avenue 21214 Funeral al Hygieno. J. other than "natural", or flems event, the Medical Examiner, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-III Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.

ant if Nem 27 is marked other than "natural", or its ury or other traumatic event, the Medical Examins Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black ğ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry B.& G. Quality College (1-4or 5+) 12th Grade Machinery Machine Company Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Cornell McNeal Patricia McGraw 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21214 19a. Informant's Neme/Relationship (Type, Print) Cornell + Patricia McNeal 3516 Frankford Avenue Baltimore, MD. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any Injury or any Injury or attes. Arbutus Mem. PK. Cem. 12-02-99 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Maryland 21202 12 an WM.C.March FH 1101 E. North Avenue 234. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Gunshor Wound Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physician and use as the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy lindings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed' HØYes 2□No 1 PYes 2 No ial or Attending Physician: Tra after death.

In Director: After this certificat ed in by the funaral director, pu 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: $_{4\square}$ Nursing Home $_{5\square}$ Residence & Dether (Specify) (Scene) X⊠ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 17 2-7 M 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Naturel 5 Pending Shot Subject 11-27-99 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide To the Hospital or Atta within 24 hours after de To the Funeral Diracto completaly filled in by the 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify)

SWEEN 4 Homicide 3500 Itmont Ave 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. November 28, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Javill rowler

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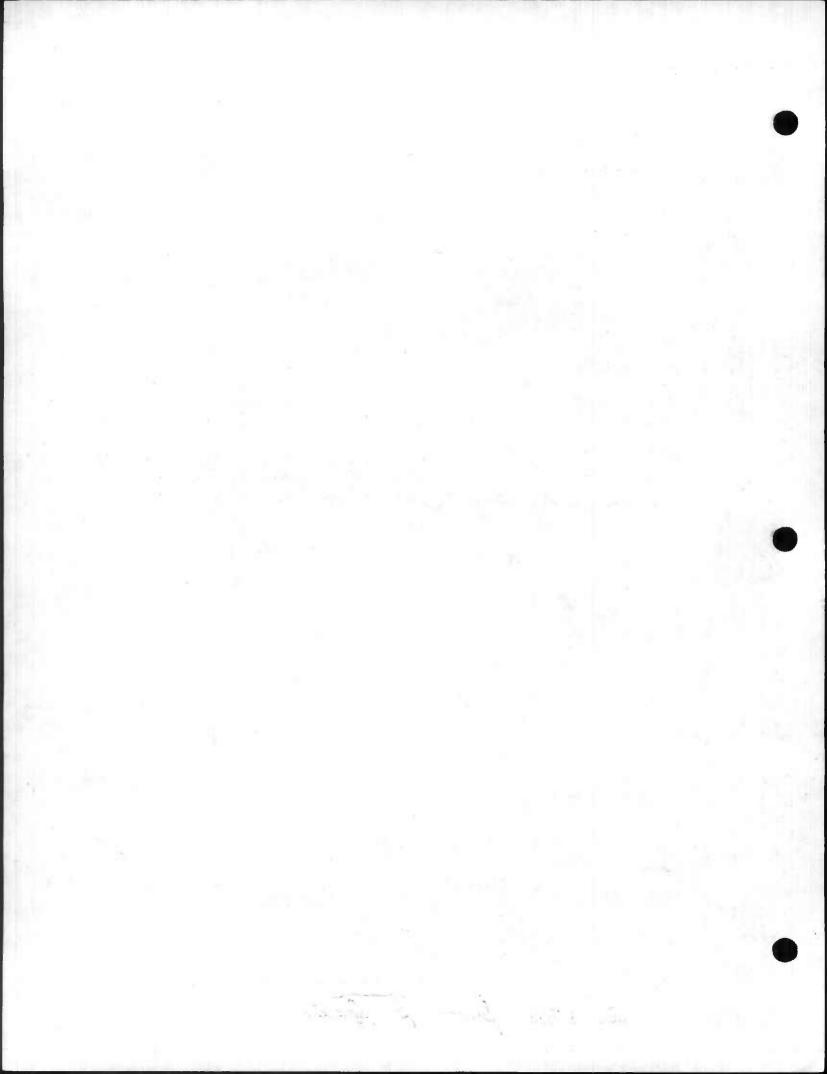
State

Registrar

31. Date filed (Month, Day, Pear)

DEC

32. Registrer's Signeture



State Registrar

DEC

31. Date filed (Month, Day, Year)

1 HOUDONE MIKE 32. Flegistrar's Signature

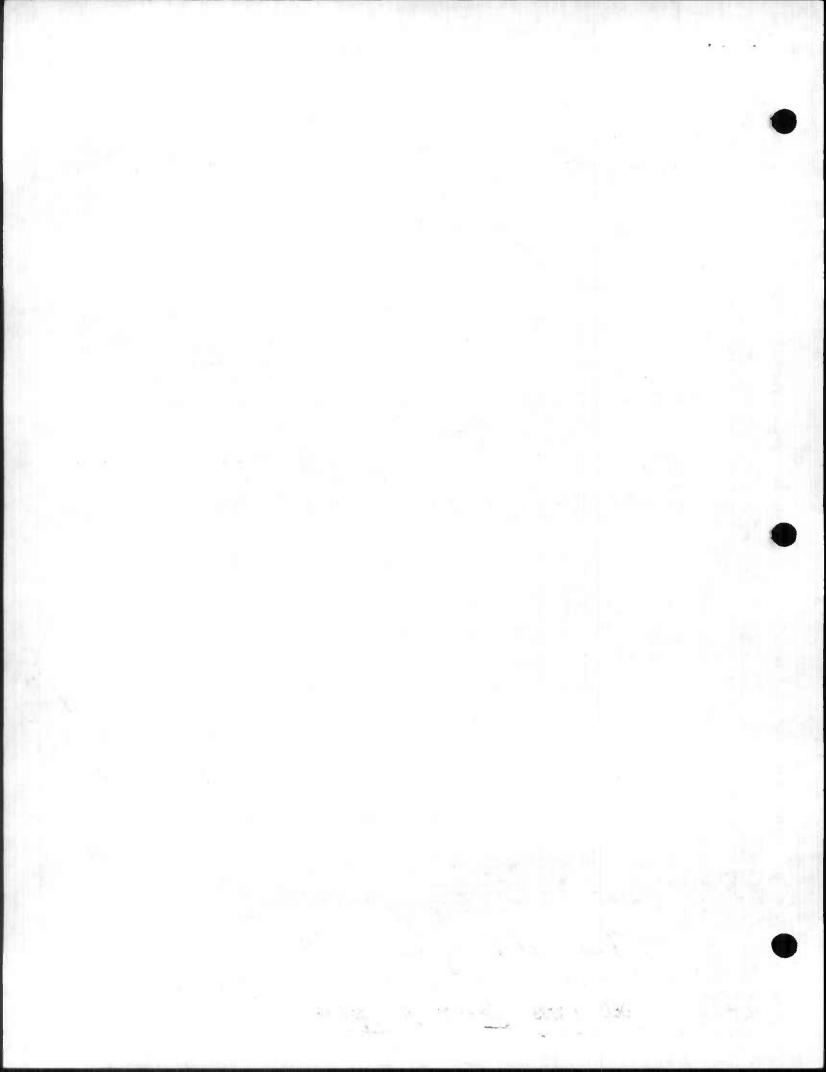
111 Penn Street, Baltimore, Maryland 21201

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29, 1999

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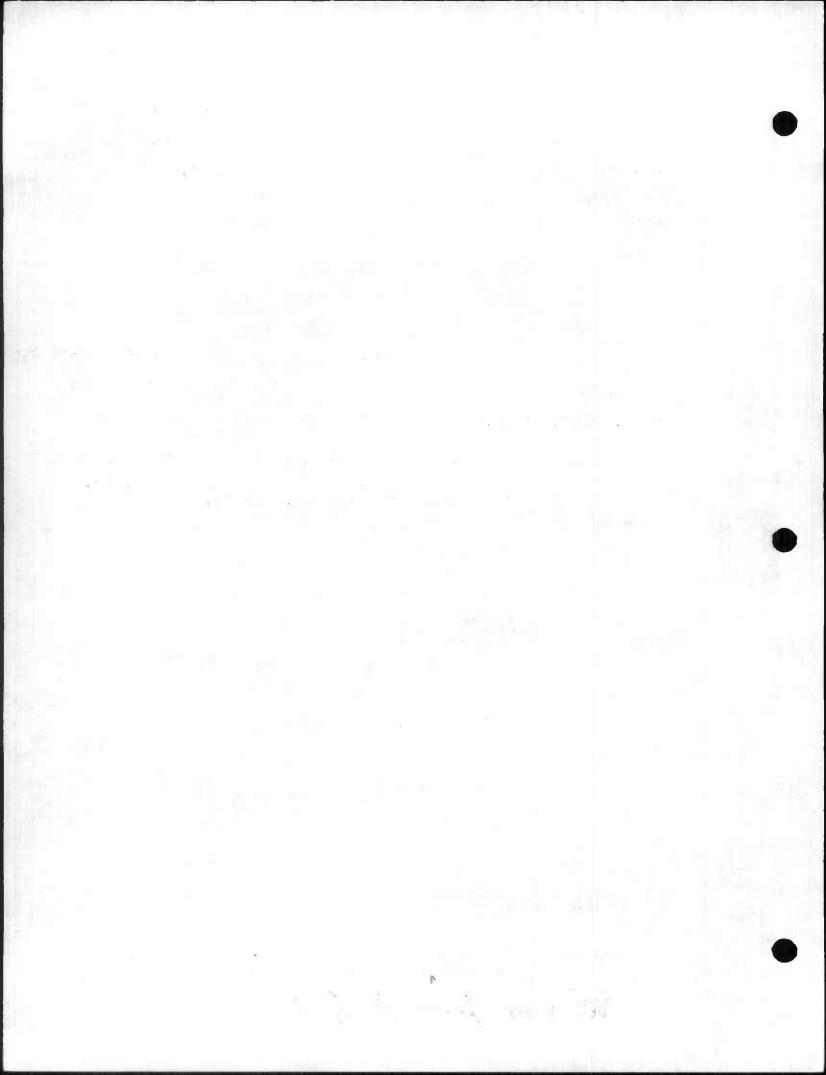
30. Name end address of person who completed cause of death (from 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 3 7 6 1 8

				Cei	rtifica	te of	Death			Reg. No.	3 3	1010
	1. Decedent's Name (First, Middle, Li	ist)							2. Date of De	ath	W	3. Time of Death
Physician /Medical	Mary Elizabeth	Matuszak							Month Novemb	er 27,	Yeer 1999	7:45 AM
Examiner	4a Facility Name (If not institution, given	e street and number)				4b. City, Towr	n, or Loc	cation of Death		ity of Death	
	East Point Nursi	ng Home					Dundal	1k		Balt	timore	
Funeral Director		Sex 7. A	ge (In yrs. last 82	birthday) Yrs.	If Unde Months	r 1 Year Days		Hrs. Min.	8. Date of Birt (Month, Da April	h y, Year) 3,1917	Cour	place (State or Foreign htty) ryland
Pue	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						1	10d. Inside City Limits
Merylen 4 show		ltimore						Dund	lalk			1 ☐ Yes 2 ☐ No
or 28s-f	10e. Street and Number	LCIMOLE			10f. Zi	p Code		Durie		10g. Citizen o	Whet Cour	ntry?
ih witi	1046 Old North	Point Roa	d				212	24		United	State	es
5-0020 72 hours else deeth with the Meryland natural', or items 23a or 28e-f show ites Examiner must be norified as		12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No				tispanic Originan, Mexican, I	n? (Spe Puerto F	cify Yes or No lican, etc.)	Spec	ace - Americ leck, White, city:	
21215-0020 d within 72 hours of glone. If then Institutel; or the Model Exemple Completed by F	15. Decedent's E (Specify only highest gr		10	6a. Deced	dent's Usu	al Occup	oation	of wordsin		16b. Kind of	Business/In	dustry
21215-0 ed within 72 ho yglene. her than "netur ft, th	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT	ise retire	during most o	A MONKE	y			
	5 Years			M	Machi	nist		a Mama	/Circl Alidella			& Seal Corp
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aryla should marke umarke	John Williams 19a. Informant's Neme/Reletionship	Tuna Print)	1.	Oh Mailir	no Address	e (Straai				er, City or Tow		
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OTO of Hear	20a. Method of Disposition		20b. Place	of Dispo	sition (Na	me of	cel		Date	20c. Location	n - City or To	own, State
Peges mt: if its my or o	1 [™] Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specia		9				12/2	/199	99	Balti	more,	Maryland
Baltimore pemil. Peges 1. Department of He important: if New eny Injury or oth page.	21. Signature of Funerel Service Lice	nsee		22 [Name a	nd Addre Ruck	ss of Facility Funer	al H	Home of	Dunda Maryla		nc. 1222
	23a. Part1. Enter the diseese, or com- shock, or heart feilure. List only	plications that cause	ed the death. D								na 2.	Approximete Intervel Between
Cay 50, while the bunder and bund	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	. De	Due to (or as	Ce	rence of)	00	asci	ill	u aa	cidu	tt	Onset end Deeth
D =	Cause (Disease or Injury that initiated events resulting in death) Last	d N	Due to (or as	a consid	uence of)	w	dy 1	rac	I cay	lectur	20	
deeth cendent for use	Part II. Other significant conditions of											o the cause of death?
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= F # 8 0									101	Yes 2 No	11	☐ Yes 2☐ No
yelcien: The yelcien: The securificate director, peg	25. Wes case referred to medical examiner?					Jay		of Death	(Check only o	one)		
- K	1 Yes 2 No	Hospital: 1 Inpet		Outpetier		UA				dence 6 🗆 C		(y)
Attending Particular (1997) Attending Particular (1997) Attending Particular (1997) Attending Particular (1997)	27. Manner of Death 1. Netural 5 Pending 2 Accident investigation		ey Year) 28	b. Time of Injury	м	28c. Inju Wo 1□	nyat rk? ∣Yes 2. No		8d. Describe	how injury occ	urred	
2 24 25	3 ☐ Suicide 6 ☐ Could not be determined	288. Place of Ir	njury - At home rkc. <i>(Specify)</i>	, ferm, str	eet, facto	y, office		2	8f. Location (: City or To		nber or Auri	al Route Number,
To the Hospital within 24 hours To the Funeral completely filled		nysician: To the best miner: On the basis of and manner s	of examination									
within 2 To the comple	29b. Signature and title of certifier	and manner s			29	c. Licens	se number			29d. Dete sign	ned (Month,	Day, Year)
F3F8	1 Marine	to, 1 50	1.000	10	1	000	no	7 5	3	121	27/1	96
5	30. Name and address of person who	completed cause of	death (Item 23	a) (Type,	Print)	6		1 -		101	0-1	/
	MARGUET	RUE	Til	101	PSI	1	M	1	ODE	33'	St	21218
State	31. Date filed (Month, Gan Year)	1999 N	rais Signature	~	0	00	acks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death AMENDED 23a, PER MD. G778, 12/1/99 DH 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath November 1999 9:50 AM ames Martin 18 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Veterans Abbairs Balhmore Itospital Baltimore City If Under 1 Yeer ff Undar 24 Hrs. 5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplece (Stete br Foreign Country) Months Deys Hours Min. 11 M 2□ F 72 215-24-5470 Yrs. 11-10-27 PA Usual Rasidance of Decedent 10b. County Baltimore 10c. City, Town or Location 10d. Insida City Limits Parkville 1 ☐ Yes 2X No 10f. Zip Code 21234 3117 Dubois Ave. 10g. Citizen of What Country? USA 12. Was Dacedent Ever In U,S. Armed Forcas? 1 12 Yes 2 □ No If Yas, Give Yaar or Datas: 46-50 13. Wes Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, 11. Marital Status Black, Whita, etc. 1 Never Merried 2 Married 1 Yes 2 No white Specify: Specify: 46-50 3 ☐ Widowed 4 ☑ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coltega (1-4or 5+) 10 0 Truck Driver Davidson Transfer 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Meiden Surnama) Thomas F. Martin Sr. Mildred Dovenbarger 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Dolores Schultz / daughter 1509 Neighbors Ave. Rosedale, MD 20b. Place of Disposition (Nema of cemetery, crametory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Ramovel from Stete Parkwood Cemetery 11-22-99 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature di Funarai Service Lice 22. Nama and Addresa of Facility Cvach/Rosedale Funeral Home enion 1211 Chesaco Ave. Rosedale, MD 23a. Pert1. Enter the disease, or complications that cause like leath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Immediata Causa (Final diseasa or condition rasulting in daath) Dua to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaase or injury Dua to (or as a consequence of): that initiated evants rasulting in death) Last Dua to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evallable prior to complation of causa of daath? 24a. Was an autopsy performed'i 2 No 1 ☐ Yas 2 ☐ No 1 ☐ Yes 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 26a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending 12 Natural 1 ☐ Yas 2 ☐ No invastigetion 2 Accidant

Examiner attending physician and for use as the buriel-transit The law requires that the death certificate be executed ed by the a signed by t Division of Vital Records, P. should I ate has b certificate or Attending Physician: director this funeral After Director: A To the nous after deev within 24 hours after deev To the Funeral Director

Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

10

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours affer c Department of Heelth and Mental Hygiene. Important: if flem 27 is marked other than "natural, or item any injury or other traumatic event, are Medical pages."

Physician

/Medical

Baltimore, Maryland 21215-0020

with the Meryland

death ,

Physician/Medicai

ð Completed Be Certification: To

25. Was case rafarred to medical axaminar? 1□ Yes ≱ No 27. Mannar of Death

6 Could not be determined 3 Sulcida 4 Homleida

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

12 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

Baltone 21201

29b. Signatura end titla of certiflar

29a. Certifier

(Check only one)

Cal

29d. Data aigned (Month, Day, Year)

P12456

Street

November 18, 1999

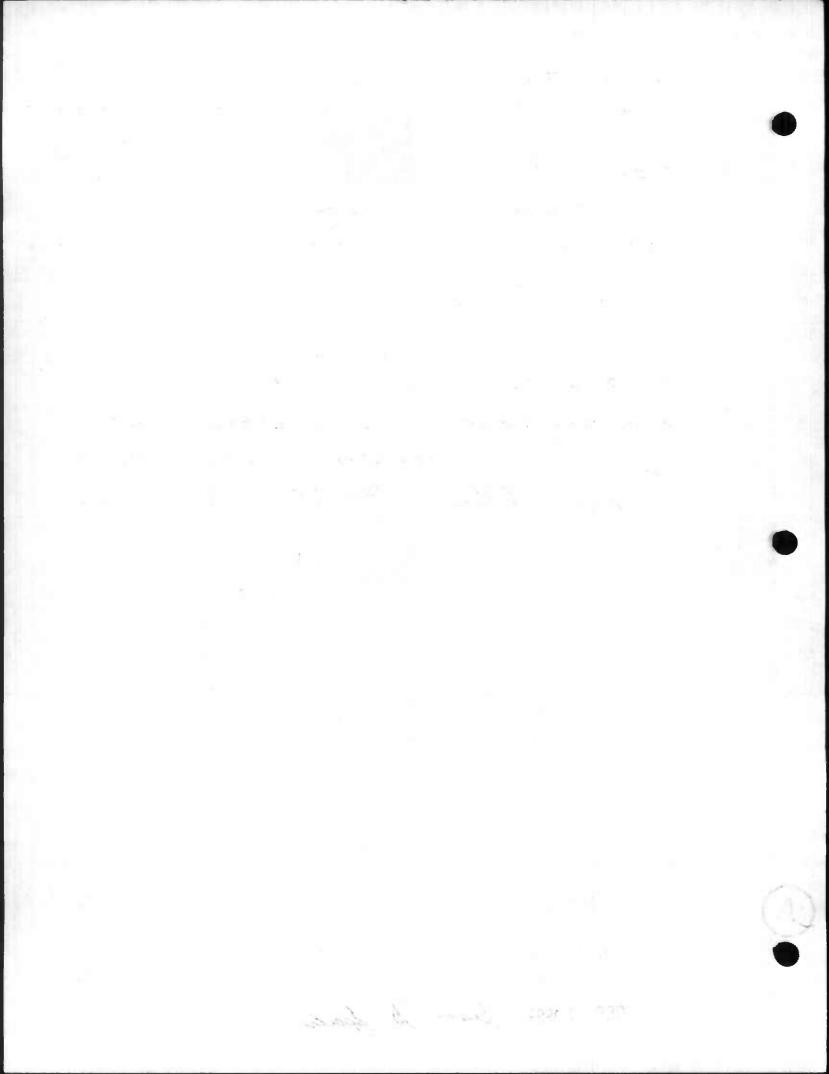
30. Nema end addrass of person why complated causa of death (Item 23a) (Type, Print) LISA NIPKOW 22 South Greene

31. Data filed (Month, Dey, Year) DEC

1999

32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month SADIE METZGER NOV. 23 1999 9:32AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner CHERRYWOOD NURSING HOME REISTERSTOWN BALTIMORE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country)
 MARYLAND 5. Social Security Number **Funeral** 1□M XXF Months 103 212-74-7984 Yes AUG. 3, Director 1896 Usuel Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD XX Yes 2 No Director N/A BALTIMORE 188-7 10e. Street end Numbe 10g. Citizen of What Country? 10f. Zip Code harns 23a or 21215 IISA 6711 PARK HEIGHTS AVE., APT. 402 Funeral 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be fits.
Deportment of Health and Mental Hy important: If Nem 27 is marked other any Injury or other traumatic events. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be SADOWSKY EVA COHEN 2 **ABRAHAM** 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addreas (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6711 PARK HEIGHTS AVE., APT. 402 BALTO., MD 21215 MRS. SHIRLEY FELDSTEIN(DAU.) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XX Burial 2 Cremation 3 Removel from Stete 11/26/99 BALTIMORE, MD AITZ CHAIM 4 Donetion 5 Other (Specify) 21. Signeture of 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN RD. PIKESVILLE, MD 23a. Pert1. Enfor the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, of neer feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Evende Examiner Due to (or es a consequenca of) Physician/Medical Examiner NEUMONICA The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last the burial-tran Due to (or as a consequence of) Box 68760. Due to (or as e consequenca of) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tre Cardiolagueula Miscora Records, þ 8 24b. Were eutopsy findings aveilable prior to completion of cause of death? Be Completed page 2 should 24a. Was an autopsy certificate has 1 Yes 2 Ho 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 Ne 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Division 5 Pending investigation 1 Nature Director: Aff 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

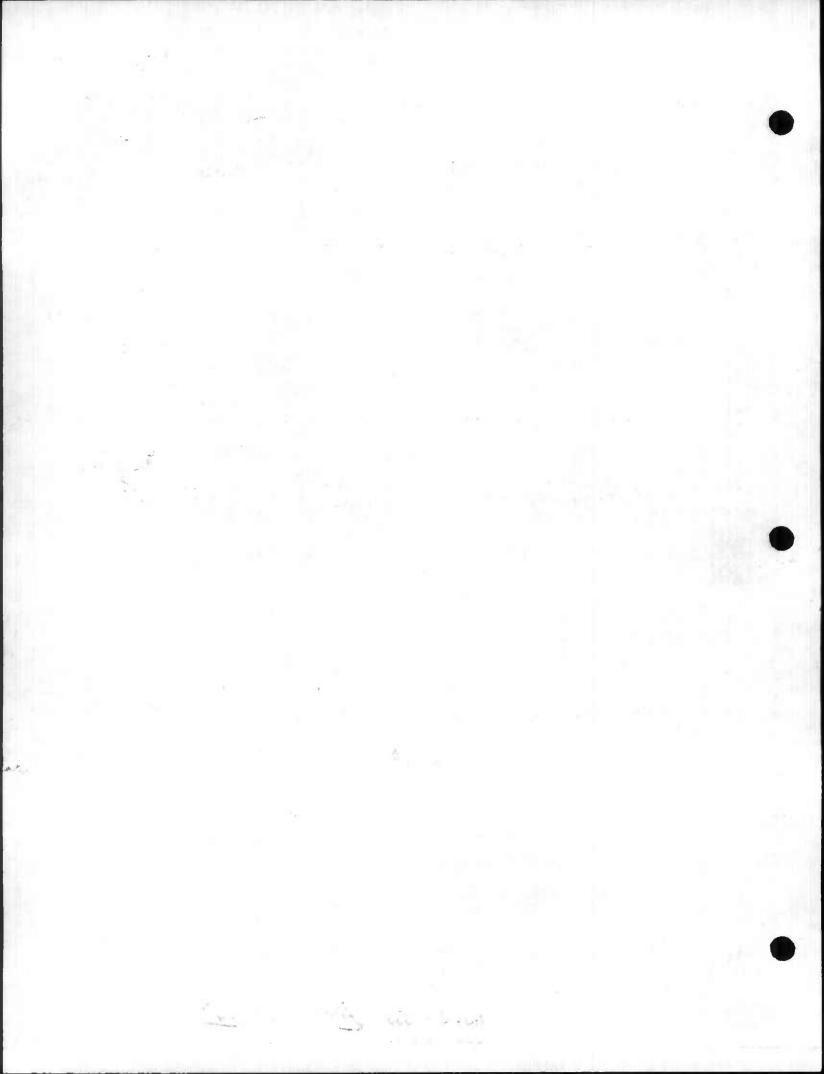
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e, Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) lt BKroog 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) Robert B. Kroopnick, Old Court Road Suite 300, Pikesville, MD 2208 4000 M.D. 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registra:

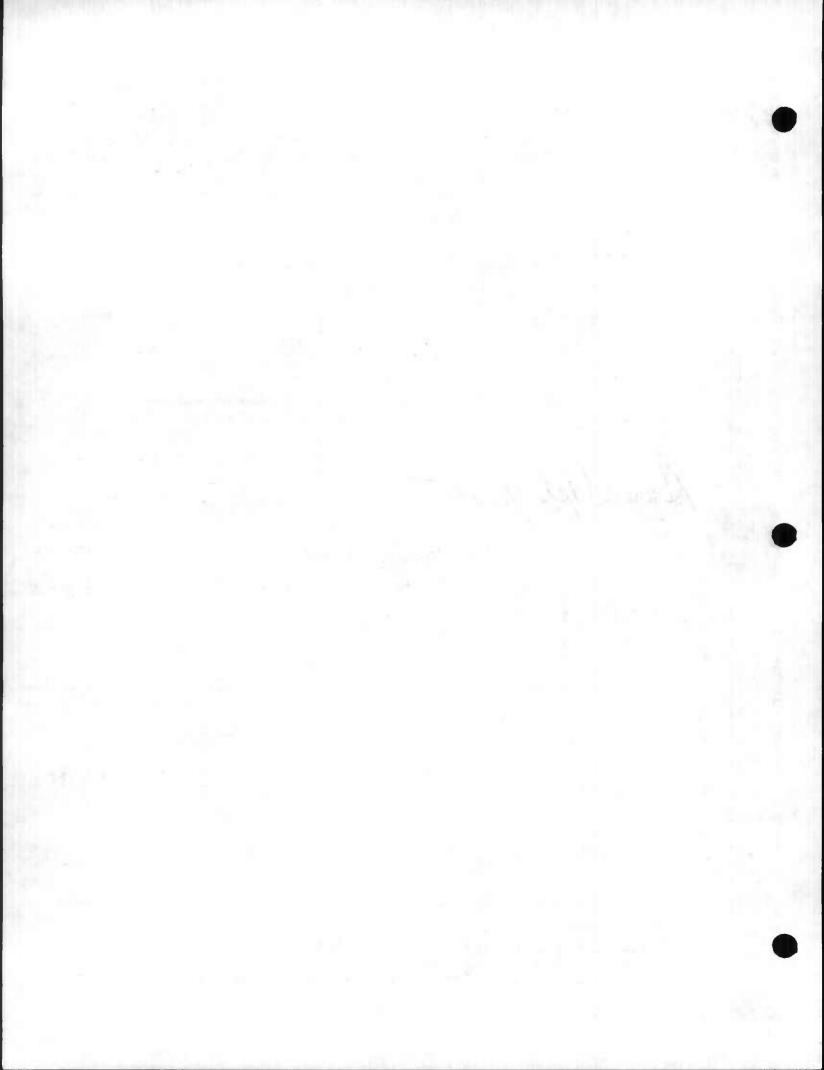
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		eg. No.	3	7621
	Physicia		1. Decedant's Name (First, Middla, Las	t)					2. Date of Dea Month	h	Year	3. Tima of Death
	/Medica	ıl .	EMMA VIRGINI		ΞY				Novembe	r 30,19	99	1:40A
	Examine	r	4a Facility Nama (If not institution, give					4b. City, Town, or L	ocation of Death	4c. County o		
_		-	3602 Jackson Co		e (In ure	last birthday)	If Under 1 Year	Phoenix If Under 24 Hrs.	8 Date of Birth	Balti		
L	Funeral Director			² M ² X ^F 57		Yrs.	Months Days		8. Data of Birth (Month, Day February	Year) 10,1942	Mary	lace (Steta or Foreign try) l and
	yland	1	10a. Stata 10b. County		10c. Cit	y, Town or Loc	ation	. 0	94		1	Od. Insida City Limits
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	vith th	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	hat Coun	try?
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lary	end Men end Men end marke aumatic		19a. fnforment's Name/Ralationship (T				The second second second	end Number or Ru				Code)
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Baltimore,	0 0 - 5		20a. Mathod of Disposition 1 ☐ Burlal 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify.	Ramoval from Stata			ition (Neme of atory or other pla			20c. Location - C		
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44		1	23a. Part1. Enter the disease or comp shock, or heart failure. Eist only of	ne cause on each lin	the daati na.	n. Do not enta	r tha moda of dyi	ng, such as cardiac	or raspiratory arr	ast,	1	Approximata Interval Between Onset and Death
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	Examiner		disaase or condition resulting in daath)	a. Cardio	Dueto	monar	y Arr	AL			1	10 minutes
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	death e atte ed for	2	Part II. Other significant conditions co	ntributing to death be	ut not res	ulting in the un	dertving causa gi	ven in Part I.	23b. Dfd to	bacco usa cont	tribute to	the cause of death?
P.0.	v requires that the death certification signed by the attending should be detached for use at the by the language.								1 U Y	2 15No	3 Prol	bebly 4 Unknown
	igned be d	2										
Orc	The law requires the cate has been signed and page 2 should be done of the cate has been signed by the cate of the								24a. Was a perform		avi	ere eutopsy findings ailable prior to mpletion of cause
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	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Martical Certification: To Re Common		7	ner: On the basis of and menner ste	examinal							
	within 2 to the comple		29b. Signature and title of certifiar	0 - 0			29c. Licen		2	9d. Date signed	(Month,	Day, Year)
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	0010	1	30. Nama and eddress of person who co				rint)	11 15	01			
	The			HeT 1		s Hepki	KS 600	N. Wolfe	St., Bal	there, 1	ND.	41287
	State Registrar		31. Data filed (Month, Day, Year) DFC 1 1999	32. Registre	J.	Span	61					



2:38 AM

Baltimore

USA

Taylor

White

Birthplace (State or Foreign Country)

Md.

10d. Inside City Limits

1 Yes 2X No

William

November 29, 1999 **Physician** WILLIAM ROBERT MARTIN, DDS /Medical 4a Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1 Nearfield Rd. Lutherville If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours Months Yrs. 220-05-1066 Director 79 July 23, 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show Directo 288-1 Md. Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Norris 23s 1 Nearfield Rd. 21093 Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: ₩₩—∏∏ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 DDS Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental H and: If Item 27 is marked off jury or other traumatic even Be Martin Florence Lo William Frederick 19a. Informent's Name/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1 Nearfield Rd. Lutherville, Md. 21093 Mrs. Carma Martin/wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Its any Injury or of once. 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/2/99 Oak Lawn Cemetery Baltimore, MD. 22 Name and Address of Facility
Ruck Towson Funeral Home, Inc. ature of Funeral Servi 1050 York Rd. Towson, Md. 21204 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one cause on each line. **Physician** Metastatic /Medical Immediate Cause (Final gastric cancer disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. þ should b 24a. Was an autopsy performed? Completed has Vital Attending Physician: 25. Was case referred to medicat examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA TO 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 1 Netural 5 Pending invastigation To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun 2 Accident 1 Tyes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner es stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature god title of certifier 29c. License number 123399 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

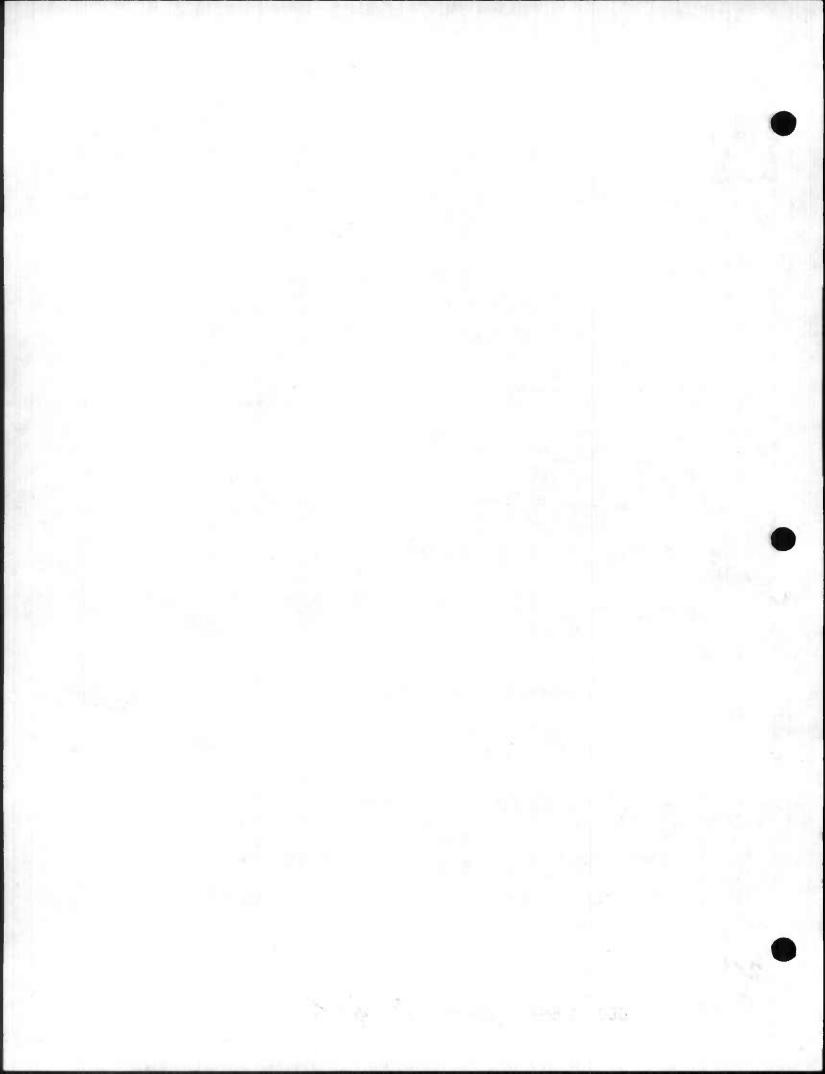
Approximata intervat Between Onset and Death 4ears 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? t ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) November 29, 1999 south

Registrar

31. Date filed (Month, Dey, Year)

1. Decedent's Name (First, Middla, Last)

DEC 1 1999 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Robinson Day **Physician** Alexander NOVEMBER 20, 1999 12:07 Pul /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTINERE If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F Director 61 July 3, 1938 MD 212-36-3236 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 N. Franklin Street 21201 USA deeth v Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unknown 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effect Insperiment of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item only injury or other traumatic event, trail indical Examinations. Bleck, White, elc. 1 | Yes 2 | No
If Yes, Give
Year or Dates: unknown 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 N Other (Specify) in state 21. Signature of Furger Service Licensee Wade, Director 25 Mart and Avert of Fry His Board 655 W. Baltimore St Baltimore, MD 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shoat, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Sepsis 2 weeks disease or condition resulting in death) Examiner malnutrition or Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physicien s the burlet 5 months P.O. Box 68760. gut syndrome Physician/Medicai Due to (or as a consequence of): Small perforation requiring resection Smonths bowel signed by the all I be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Left pneumothwax Records, à 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No certificata Division of Vitai funaral director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1) Inpatient 2 ER/Outpatient 3 DOA 함 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month. Day Year) 28c. Injury at Work? After 1 Matural 5 Pending investigation within 24 hours after deeth. To the Funeral Director: Al completely filled in by the fu 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edicai 29a, Certifier \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wolfenden, Mp RES-DOD November 20, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HH.

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's/Signature

1 1999

LINDA WOLFENDEN, MD. JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST., BALTIMORE, MD 21287

Souks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BILL JAMES 1999 RILES Josember 27 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner MERCY HOSPICE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 12MM 20 F 239-34-5934 Director JAN 19 1927 NORTH CAROLINA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show XIX Yas 2 No Director notifie MARYLAND N/A BALTIMORE CITY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23a or 2504 Woodbrook Avenue 21217 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 200 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRANSPORTATION 6th grade permit. Pages 1 and 2 ahouid be file.
Department of Health and Mental HygImportant: If Nem 27 is marked other
any Injury or other traument 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 20 SPENCER RILES JOHNSIE BENNETT 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ozzie L. Riles/Wife 2504 Woodbrook Avenue, Baltimore, Maryland 21217 20a. Method of Disposition

14☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other placa) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 12-2-99 LANSDOWNE, MARYLAND 21. Signature of Funeral Service License 22. Nama and Addrass of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA Mara 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heart teiture. List only one cause on each line. Approximate Intervet Between Onset and Death Physician /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use pontribute to the cause of death? P.O. signed by 1 Yes 2 No 3 Probably 4 Unknown Records. þ cate has been significant category. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy rthis certificate h 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, i Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1€ Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire-completely filled in b 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) D40854 24 44 M 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Rycher 19 32. Registrar's Signature St Paul Pl Bultrer and 301 Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month RIDLEY 2:15 PM KENNETH 24, 1999 NOVEMBER 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death 7. Age (In yrs. last birthd) Johns HOPKINS BALTIMORE, CITY If Under 1 Yee Birthplaca (Stete or Foreign Country) 5. Social Security Number 216-40-071 12M 20 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No HARFORD EDGEWOO 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 1015 2109 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Stetus Armed Forces? 1 Pres 2 No If Yes, Give Year or Dates: 75 80 Specify: BEHCK 1□ Yes 21 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 115 Soldien 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ERNEST RIDLE UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) THERESA WEND 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disagree, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or resistock, or heart tailure. List only one cause on each line. HOSAS AXE Approximete Interval Between Onset end Death Immediate Ceuse (Finel MYOCARDIAL INFARCTION ONE MONTH disease or condition resulting in deeth) Due to (or as e consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPERTENSION 1 Yes 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

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Box 68760

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29a, Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certified WILLIAM W. LECATES 29c. License number 29d. Date signed (Month, Day, Year) RES - \$ \$ 9 NOVEMBER 24, 1999 HOUSE OFFICER

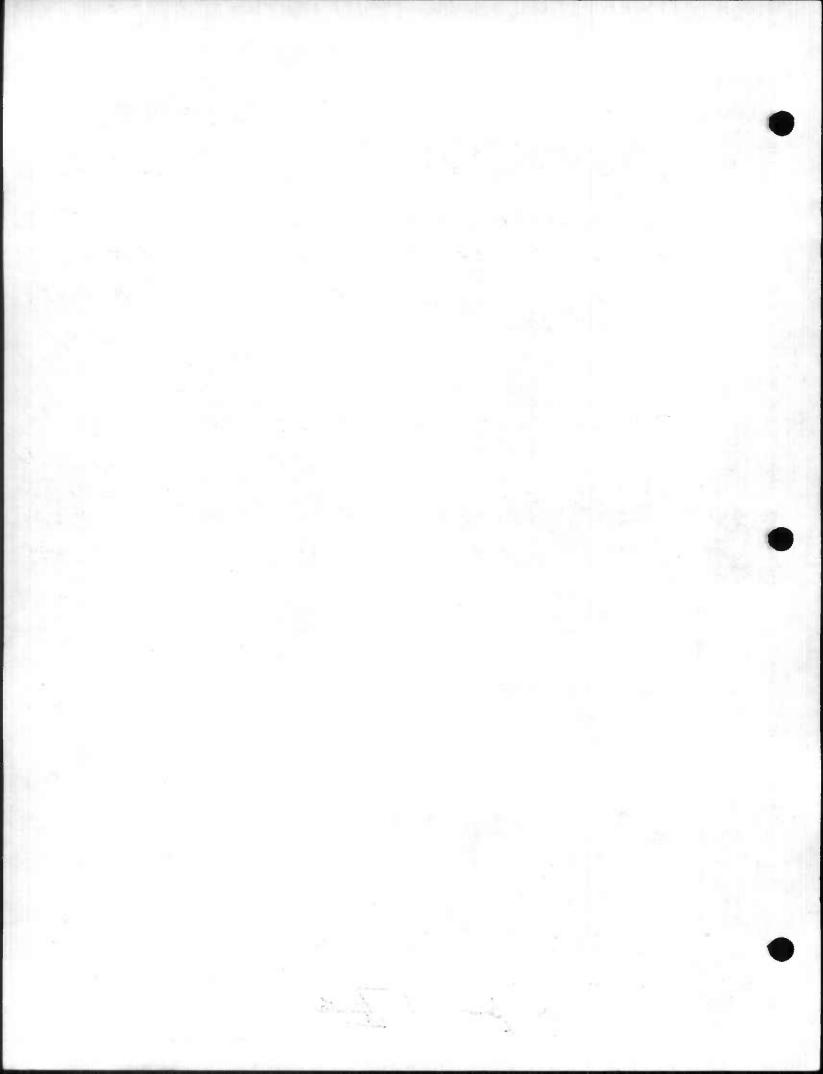
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM W. LE CATES, MD. TOWER 110, JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND

State Registrar 31. Date filed (Month, Day, Year) 1 1999 DEC

32. Pegistrar's Signature

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death Month Des REISIG NOVEMBER 21, 1999 11:30 AM 4e Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 6350 RED CEDAR PLACE #413 BALTIMORE N/A If Under 24 Hrs. 8. Dete of Birth Month, Day, Year) JAN 27, 1905 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Birthplece (State or Foreign Country) MD 10 M 2 F Months Days Hours 218-09-4788 94 Usual Residence of Decedent 10a Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6350 RED CEDAR PLACE #413 21209 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 □ Navar Married 2 □ Merried WHITE 1 ☐ Yas 2 No Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) LOUIS WISE FANNIE RUBTN 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULA BERGER / DAUGHTER 6 SAXONY COURT - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Ramoval from Steta 4 Donarion 5 Other (Specify) BALTIMORE HEBREW CEMETERY 11/23/99 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Perf. Effer the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tellure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximete Intervel Between Onset end Deeth Immediate Cause (Fine) disaase or condition resulting in death) Condro Vasoular Deseave Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or Injury that initiated avents rasulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 00 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? ssantial themoz 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical

De BIBOL

The law requires that the deeth

68760

Box

P.0.

Division of Vital Records.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Nema 23a

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el Hygiene.

permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If them 27 is marked other any Injury or other traumatic event.

filed within 72 hours after

21215-0020

Baltimore, Maryland

traumatic event, the Medical Examiner must be notified at

Funeral Director

Completed by

Examiner 96 138 88 10 certificate has this

Certification: To

Completed by Physician/Medical Be

Physician: s after deem. or Attending within 24 hours of edical completely

> State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year)

OSOPH

27. Menner of Death

1 Netural

2 Accident

3 Suicide

29e. Certifier

29b. Signatur

4 Homicide

(Check only

5 Pending investigation

6 Could not be determined

DOCKELBAUM,

28a. Dete of injury (Month, Dey Year)

who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signature

28b. Time of

28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28c. Injury et Work?

29c. License number

1 Yes 2 No

3635 OLD COURT RD.

ORIGINAL

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

28d. Describe how injury occurred

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth MALCOLM RIEMER 1934 VOV 24 /959 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE 5. Social Security Number N/A HUSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | FEB.10,1935 6. Sex 1 🕅 M 2 ☐ F 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 287-26-5647 Yrs. 64 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No OH **CUYAHOGA** SOLON 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5590 JANET BOULEVARD 44139 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 💆 Divorcad 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ DENTIST DENTAL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) RIEMER **ESTHER** WEINER MAX 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LARRY RIEMER / SON 5900 EDSON LANE - BETHESDA, MD 20852 20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriei 2 ☐ Cremetion 3 ☑ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) ZION MEMORIAL PARK 11/29/99 BEDFORD HEIGHTS, OH 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 complications at caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cardiac or respiretory errest, att. Enter the diseese, or comshock, or heart feilure. List only Immediate Ceuse (Finel diseese or condition resulting in deeth) Pulmonary Embolism Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequença of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 KER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rail, or items 23s or 28a-f shore Examiner must be notified at

traumatic event, the Medical

e filed within 72 hours after al Hygiene. other than "natural", or ite

Peges 1 and 2 should be fament of Health end Mental It item 27 is marked of

or other

permit. Pege Department of Important: If any injury or once.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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> Examine Physician/Medical p Completed Be

Box 68760 4 of Vital Records, page 2 certificate Medical Certification: To # Aller 6

LEMER, MALLOLM

To the Funeral Completely Illed

State Registrar

ERIC SHEPARD 31. Date filed (Month, Dey, Year) NOV 2 9 1999

29b. Signature end title of certifier

1 Yes 2 No

5 Pending

investigation

6 Could not be determined

27. Menner of Death

Neturel

2 Accident 3 Sulcide

4 Homicide

29a, Certifier

28a. Dete of Injury (Month, Day Year)

D 47484

1 ☐ Yes 2 ☐ No

28c. Injury et Work?

1 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the cause(s) end menner stated.

29c. License number

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

900 CCTUN AVE Baltimore, MD

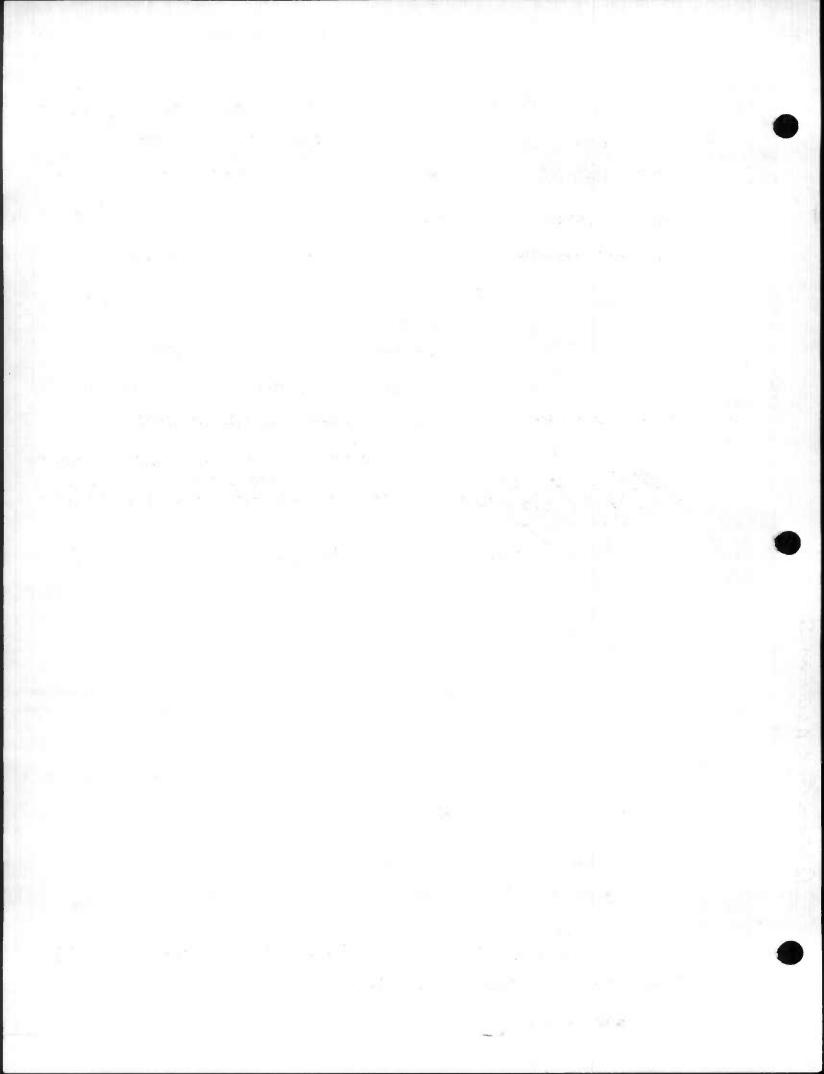
28d. Describe how Injury occurred

32. Registrer's Signeture

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95



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			1. Decedent'a Nar	me (First, Middle, La	st)					2. Date of De			3. Tima of Death	
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1		/Medical Examiner	4a Facility Name		e street and number)	KAIVK		RUL		Location of Deal	h 4c. County		1. 10 /1/	
	4	Examiner	44		TALOF	an.	-1 11 01	· ve	BAL-	TIMORE	N/A			
	3-	Funeral	5. Social Security	Number 6. S	ex 7. Ac	e (In yrs. last	birthday)	If Under 1 Ye	ear If Under 24 Hr	s. 8. Date of Bi		9. Birth	place (State or Foreign	
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0		i or 28a-f all be notified	10e. Street and No	umber				10f. Zip Cod	de		10g. Citizen of	What Cou	intry?	
2		23a or	2153-A	WOODBOX L	ANE				21209		U.S.	Α.		
6		thar death with the Maryland r flams 23e or 28e-f show there must be notified at Funeral Director	11. Merital Status		12. Wes Decedent	Ever in U,S.	13. Wa	s Decedent	of Hispanic Origin? (Specify Yes or No	- 14. Rac		can Indien,	
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5	05	by by	3 ☐ Widowed	4 Divorced	If Yes, Give Year or Dates:			JYes 2XX	No Specify:		Specify	/ :	WHITE	
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7			19a. Informent'a P	Neme/Relationship (Type, Print)	1	9b. Mailing	Address (St	reet and Number or F	Rural Route Numb	I Route Number, City or Town, State, 2		p Code)	
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	Ba	Departm Departm Importa any Inju	11/1	1.19	*								DS., INC.	
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4			shock, or he	art failure. List only	pication that caused one muse on each is	d the death. L ne.	o not enter	the mode of	dying, such as cards	ac or respiretory e	rrest,	1	Approximete Intervel Between Onsel end Deelh	
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4		/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) SEPSIS											
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	5	ysicien: s certific director,	examiner?	No	Hospital:	ent 2 ER/	Outnotions	2[] DOA	Other	Home 5□ Res		ne (Cono		
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		he Hoepit in 24 hour he Funer pletely fill edical	(Check only one)	2 Medical Exam	niner: On the basis of and manner st	f examination	and/or inves	stigation, in r	my opinion, death occ	curred at the time	date end plece,	and due	to the cause(s)	
		To the Hospital or At within 24 hours effer or To the Funerei Direc completely filled in by Medical Certifi	29b. Signature and	d title of certifier	and market su	anou.		29c. Lir	cense number		29d. Date signe	d (Month	Day, Yearl	
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DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

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Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O.O.

	23a, Per MD, G778, 1 1. Decedent's Nama (First, Middle,			ertificate of	Doutt	2. Data of Dea		3. Tima of Death
sician ledical		Clayto	on Ruhl	and		Novembe Novembe	er 18 1	999 5:40 P.N
miner	4a Facility Name (If not institution,				4b. City, Town, or Lo		,	
	North Arundel 5. Social Security Number	-	(In yrs. last birthd	(RV) If Under 1 Year	Glen Burn			Arundel
ral or	216 01 9192 Usual Residence of Decedent	183 M 2□F	82 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Dey Sept. 8		Birthplace (Steta or Foraig Country) Maryland
	10a. State 10b. County		10c. City, Town or	Location			100	10d. Inside City Limits
tor	Maryland Anne A	Arundel	Pasader	na				1 ☐ Yas 2√2 No
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	1910 Cedar Road	d		2112	22	- 4	U.S	•
Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? d 17 Yes 2 No.	0	3. Was Decedent of H tt Yes, specify Cuba 1 ☐ Yes 2 ☒ No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No- Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. White
	15. Decedent's (Specify only highast Elementary/Secondary (0-12) 8th		(G	cedent's Usual Occup ive kind of work done a. DO NOT use retired	during most of work	ing	16b. Kind of Bu	
	17. Father's Name (First, Middle, La	ast)			18. Mother's Name	(First, Middle,		
900		Henry Ruhla	nd		Ka	therine	Schlabe	ecker
	19a. Intorment's Neme/Relationship	p (Type, Print)		ailing Address (Street		al Route Numbe	r, City or Town,	State, Zip Code)
	Donna Cain /	Daughter		3 Miramar		Pasade	na, Mar	
	20a. Method of Disposition 1 ☑Burial 2 ☐ Cramation 3	B □Ramoval from Stata		sposition (Neme of cremetory or other plea	4 4	Date (OO		City or Town, State
	4 ☐ Donation 5 ☐ Other (Spe	ecity)	Md. Sta	te Veteran		/22/99	Crownsv	ille, Maryland
	21. Signature of Funeral Service Lie	Drone		22. Name and Addre				Home P.A. Md. 21225
Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Arter	Due to (or as a con-	c Cardiovascu	ular disease	>		
	Part II. Other eignificant conditions	contributing to death but	not resulting in the	a Adenying cause giv	en in Part I.	23b. Dld to	obacco usa con	ntributs to the cause of death
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combiered of						24a. Was a perfor		24b. Were autopsy tindings available prior to completion of cause of death?
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	25. Was case reterred to medical exeminer?				26. Place of Deet	n (Check only or	ne)	
9	1 ☐ Yes 2 No	Hospitel: 1 Inpatien			4LI Nursing Ho		ence 6 Othe	
0	27. Menner of Death Neturel 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	y Wor		28d. Describe h	ow injury occurr	ed
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ertifica			my knowledge, de	eth occurred at the tir	me, date and place,	and due to the o	ause(s) and me	nner as stated.
	29a. Certifier Check only 2 Medicat Ex	Physician: To the best of carniner: On the basis of and manner state	examination and/or	invastigation, in my o	pinion, deeth occurr	ed et the time, o	tete end place, a	and due to tha cause(s)
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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Month Day 28 Physician 250 Am * /Medical 4a Facility Nama (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** der 24 Hrs. 8. Date of Birth (Month, Day, JAN. 19, dical Center Meecy HIMORE 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2√ F Yrs. 219-38-4961 59 Director VIRGINIA Usual Residence of Decedent with the Merylenc 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frems 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at 1 ☐ Yas 2 No Director MARYLAND ANNE ARUNDEL BROOKLYN PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5103 WASENA AVENUE 21225 U.S.A. death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Yaar or Datas: 14. Raca - Amarican Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter c Depertment of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical 1 Nevar Married 2 N Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) VESTER **MEADOWS BERTHA** STILLWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MELVIN SEITLER- HUSBAND 5103 WASENA AVENUE, BROOKLYN PARK, MARYLAND 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State GLEN HAVEN MEMORIAL PARK 12/1/99 GLEN BURNIE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD 21061 Approximata Interval Between Onset and Deeth 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medicai Immediate Cause (Final disaase or condition resulting in death) Examiner Examiner physician end the buriel-trensit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. thet the death certificete be Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown Breast Records, Aq 24b. Were autopsy findings available prior to completion of ceuse of daath? 24a. Was an autopsy Completed been 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At homa, farm, streat, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 Homloide Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuae(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or inveatigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29c. Licensa number 29d. Date aigned (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 301 SAINT PAUL PLACE, BALTIMORE, MARYLAND 21202 DR. M.J.FELDMAN 1993 Registrate Signature State Registrar

DHMH 16 Rev 6/95

BEE 1 :399 James B. January

A THE RESIDENCE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death November 26, 1999 **Physician** Sadie homa /Medical 4a Facility Nama (If not institution, giva street and number 4b. City, Town, or Location of Death Examiner Greneral 5. Social Sacurity Number ltimore 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth 6. Sex Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours Min 10 M 201 250-/2-6588 Usual Rasidanca of Decedant Yrs. Director 10c. City, Town or Location 10a State 10b. County 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with tha Maryla Department of Health and Mental Hygiana. Important: if Item 27 is marked other than "natural", or flams 23e or 28a-f show any lipty or or other fraumatic event, its fleating Examiner must be notified a 1 4 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Thee 2/2/ Funeral 13. Was Dacedant of Hispanic Origin? (Specify Yas or NoIf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Navar Marriad 2 ☐ Married 1□Yas 2□No If Yas, Giva Yaar or Datas: Specify Black by 3 12 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elemantary/Secondary (0-12) adie-Mac NURSE PRIVATO 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Be Mattie rince (70wan Green 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) niece 3914 Rokeb 20b. Place of Disposition (Nama of commatary, cramatory or other pla Rokeby Both. Catherine MD Holmes 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Buriai 2 Cramation 3 Ramoval from Stata 12/4/99 Marylan Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral \$arvica Licensee Close 23a. Pert1. Enter the disaese, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Finel disaase or condition rasulting in death) Examiner Pardiovascular Disease Examiner ician and burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last ettending physician for use as the buria Box 68760 Physician/Medical Due to (or as a consequence of): signed by the ettendin d be dateched for use Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown nasarca Macronudular þ 24b. Were autopsy findings availabla prior to completion of cause of daath? Completed 24a. Wes en eutopsy 1 PYes 2 No 1 Yes 2 No this certificata Division of Vital I or Attending Physician: after death. Director: After this certifica 25. Was casa rafarrad to medical Be 26. Place of Daath (Chack only ona) axaminar' Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 Inpatiant 0 2 ER/Outpatient 3 DOA funaral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not be determined To the Hospital or Atterwithin 24 hours after der To the Funeral Director complately filled in by the 3 Sulcida 28e. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, deta and place, and due to the cause(s) and mennar es steted. 2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signatura and titla of certifian 29c. Licensa number 29d. Data signed (Month, Day, Year) MD 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) General Napital

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32. Ragistrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Death NOV. SHANNON IRVIN 22. 4a Facility Name (If not Institution, give street and number) LEVINDALE 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE If Under 24 Hrs. If Under 1 Year 8. Date of Birth JULY 23 1931 Birthplace (Stata or Foreign (Stata or Fore 5. Social Security Number 7. Age (In yrs. last birthday) Hours 1**∑** M 2□ F 68 Yrs 129-26-6745 Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE MD. 1X Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2434 W. BELVEDERE AVE. USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Biack, White, etc. 1 Nevar Merried 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BENDIX COMPANY COMPUTER PROGRAMER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ESTHER BLUMA OSHRY BENJAMIN BERNARD SHANNON 19e. Informent's Neme/Relettonship (Type, Print) SELMA OWRUTSKY/ SISTER 19b. Mailing Address (Street and Number of Rural Route Number City of Jown State Zip Code) 117 20b. Plece of Disposition (Nama of 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) LUBAWITZ NUSACH ARI (NER TAMID) NOV 23/ ROSEDALE, MD. Funedal Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. itions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, a cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Fine) moule disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 2[]No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 112 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? 1 Naturel 5 Pending

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permit. Pages 1 and 2 should be filed will Department of Heelth and Mentel Hygiens Important: If Item 27 is marked other tha any Injury or other traumatic avent, the IDDGs.

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2 Accident

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29b. Signatura and titla of certifiar

3 Suicide

29a, Certifier

Baitimore, Maryland 21215-0020

the Medical Examiner must be notified at

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State Registrar

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30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W Behude

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

🗠 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

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NOV. 23.

31. Dete filed (Month, Day, Year)

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6 Could not be determined

32. Registrer's Signature

Louis A. 1866 MEI 1 1 53

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	Funeral Director	5. Social Security Number 212–30–209	0 1	1. Sex 7. Age (In yrs. 68			Months Devs		8. Dete of Birt (Month, Da MAR . 22	,1931	9. Birthplace (State Country) MI	
yland	¥ =		County			City, Town o					1	10d. Inside City Limits
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T C	hygiene. wher then "natural", ent, me Medical Ex-			ucation de completed)		- (G	ecedent's Usuel Occupive kind of work done fa. DO NOT use retire	pation during most of world)	king	16b. Kind of Bu		dustry
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Maryland	To Tree	LOUIS					MASH	MARY	Esta			COVER
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Baitin	Department Important: if any injury o poce.	4 Donation 5 D				BETH E	L MEMORIAL 22. Name end Addre		1/23/99		-	OWN, MD
m a	any and a	SOL LEVINSON & BRO 8900 REISTERSTOWN ROAD — PIKESVILLE, 23a. Vert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,										
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Box 68760, death certificate be executed	etending physicien and for use as the burial-transit claryMedical Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, ate	c. Hy	nee	ten	sequence of):					
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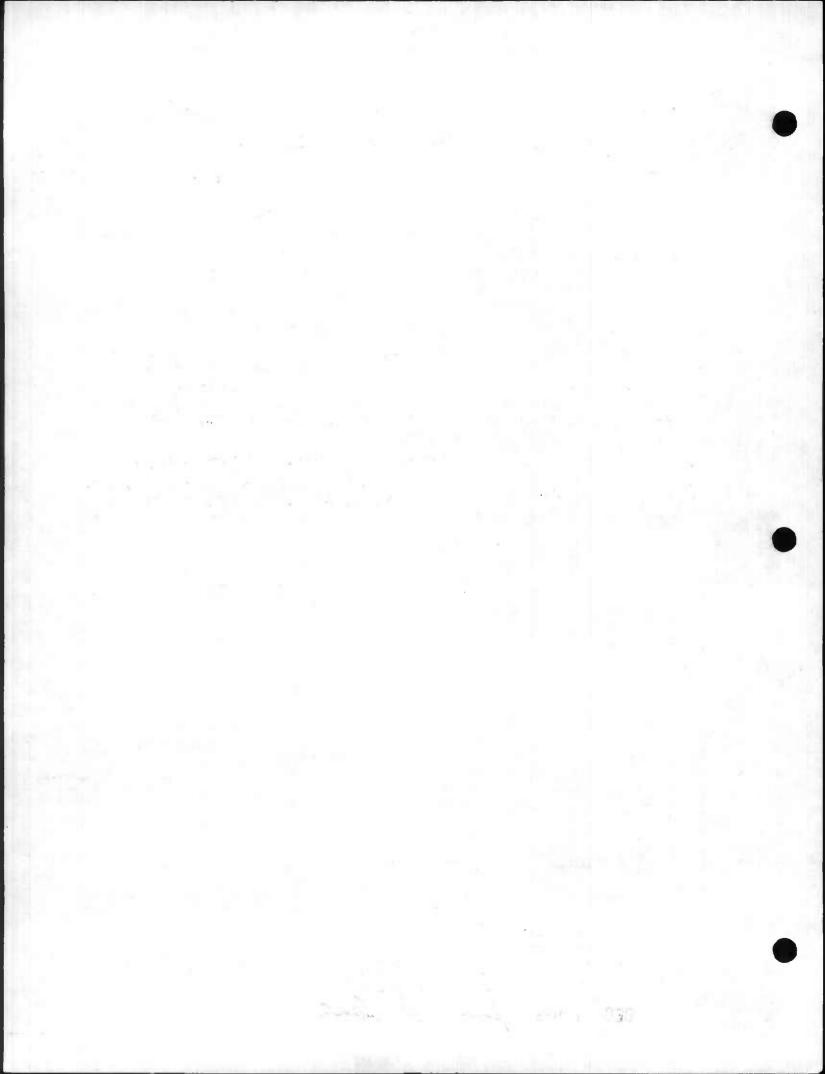
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month 1999 NOVEMBEL /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, of Location of Death 4c. County of Death Examiner 0 IMORE If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs. 199-07-2886 Director 2, Pennsylvania Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🖾 No Maryland Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7530 Lange Street 21224 United States death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Maritel Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 'natural', or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: p 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Years permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flam 27 is marked other any Injury or other traumatic avent abda. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Musser Elsie Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1923 Dineen Drive Vickie McArdle (Daughter) Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Toremation 3 ☐ Removel from Stete 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 12/1/1999 Towson, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. horsely 7922 Wise Ave. Dundalk, Maryland 23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical e t Due to (or es e consequence of) signed by the all Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy page 2 1□Yes 2□No 1□Yes \$ENe certificata Division of Vital Hospital or Attending Physician: director, 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes ZE No Certification: To this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Natural 5 Pending in 24 hours after death.
The Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Dil completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (flem 23s) (Type, Print) 31. Date filed (Month, Dal Year) 32. Rugistrar's Signature State 1 1999 DEC Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#24a PER MD. G778 12-1-99 J.A. Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Day **Physician** 5.32 AN NOVEMBER Louis Julius Shub /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Paul Place 301 Baltimore City Stella Maris/Mercy If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth | Months | Days | Hours | Min. | Feb | 19, Year | 1912 Birthplace (State or Foreign Country) MD 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 1₩ 2□ F MD 219-28-9922 87 Yrs. Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 TYO Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3408 Washington Avenue 21244 USA 12. Was Decadant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc 1 ☐ Yas 2 ☐ No If Xes, Giva Yaar or Detas: 41-45 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: þ Specify White 3 Widowed 4 Divorced Be Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elemantary/Secondery (0-12) concert pianist cultural arts 17. Fathar's Nama (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumeme) Boris Shub Bessie Leah Sagalof 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Vivienne Shub/wife 3408 Washington Ave, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Buriai 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Specify) 21. Signature of Punaral Service Ligary Wade, Director 22. Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final disaasa or condition rasulting in deeth) Due to (or es a consequence of) Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributs to the cause of death? 1 Tyss 2 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Be Completed 1 Tyas XX No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Homa 5 Residence Medical Certification: To 1 Yas Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Panding invastigation 1 □ Yas 2 □ No 2 Accident 6 ☐ Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide

Physician: The law requires that the death certificate be executed of Vital Records, P.O. Box 68760,

Funeral

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

ant: If Itam 27 Is marked other than "natural", or Itams 23s or 28=f ahow ury or other traumatic avant, the Medical Emerical ment be notified at

Department of Important: If any Injury or

Physician

/Medical Examiner

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Baltimore, Maryland 21215-0020

Division	To the Hospital or Attanding	within 24 hours after death.	To the Funeral Director: After	completely filled in by the fun
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State Registrar

30. Nama and addrass of person who comp 31. Dete filed (Month, Day, Year)

NOV 1 8 1999

29b. Signature and titla of certified

29a. Cartifier

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301 32. Registrer's Signetura

ed causa of death (Item 23a) (Type, Print)

DHMH 16 Rsv 6/95

🕊 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date and place, and dua to tha causa(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

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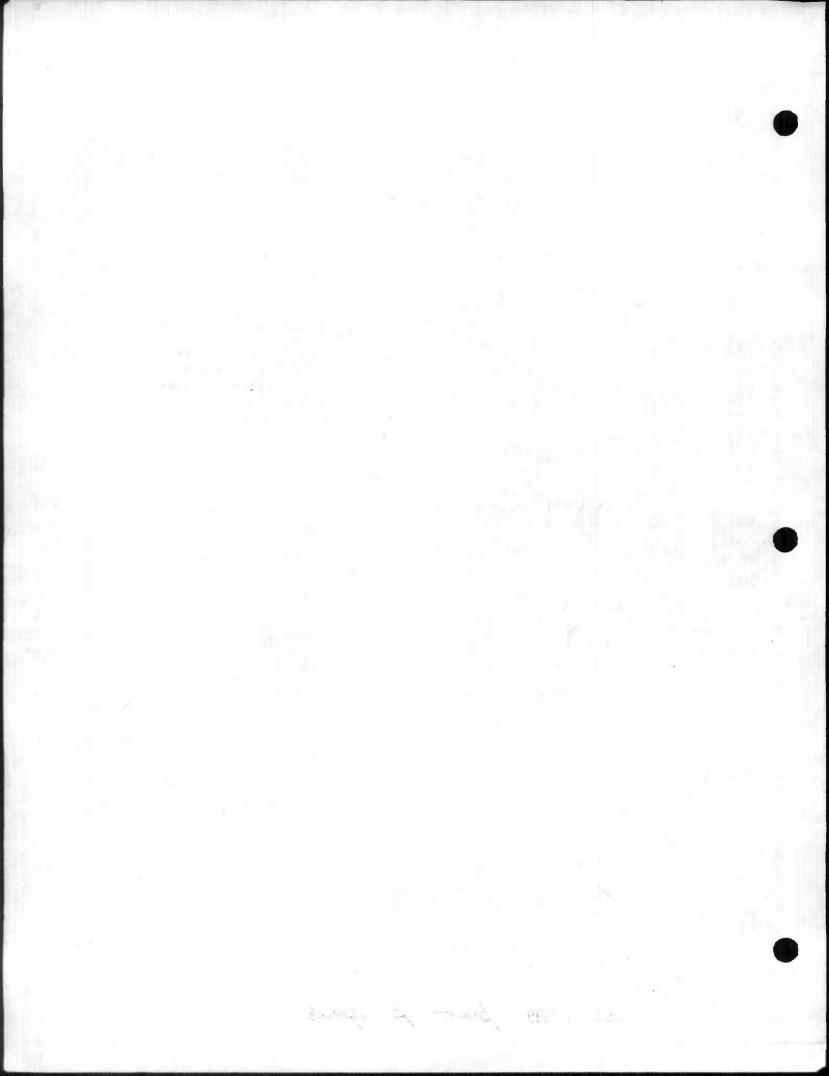
29d. Data signed (Month, Day, Year)

NOV 1 8 1999

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State of Maryland / Department of Health and Mental Hygiene 99 37637

	Certificate of Death	Re	g. No.	3/63/									
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/Medical	PAUL EDWARD VEST	Nov. 2	26 1999										
Examiner	4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or L	ocation of Death	4c. County of Deatl	1									
N.C.	498 North Stuart Street Essex Baltimo 5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 9. Birthplat Country (Month, Day, Year)												
Funeral Director	234-44-1846 USU M 2 F 7. Age (in yrs. last birthday) Months Deys Hours Min.	Month, Day, Feb. 8 19		pplace (State or Foreign untry) t Virginia									
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P S P Ö	I there Middle 1 D 26835		11/29	199									
WIN	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2122	7										
Since	31. Dete filed (Month, Day, Year) 32. Registrar's Signature	ULL	_										
State Registrar	DEC 1 1999 Denve & Sparks												



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth October 1 9999 9:00AM Sophie Wilcox 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Mariner Health of Overlea If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1 □ M 2 X F Yrs. 214-20-1965 Oct 16, 1923 MD Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. inside City Limita 10b. County MD N/A Baltimore 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21206 USA 6116 Belair Road 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Neme (First, Middle, Maiden Sumeme) unknown unknown unknown 17. Fether's Neme (First, Middle, Last) unknown unknown 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Gertrude Phillips/friend unknown 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 🖺 Other (Specify) in state 21. Signature of Pynera Service Licensee. Wade, Director 25 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 much 23a. Fart1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntervet Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) (upper) bleed Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilebie prior to completion of cause of death? 24a. Wes an autopsy performed? 2 DONO 1 Yes 2 No 20 Olres 26. Place of Death (Check only one) Hospitel:

Examiner Box 68760 P.O. Division of Vital Records.

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Physician

* /Medical

Examiner

Director

Funeral

by

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Funeral

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

"natural",

permit. Pages 1 and 2.9
Department of Health at important: If Itsm 27 is any injury or other traugnos.

Physician /Medical

12 should be filed within 72 hours efter death n and Mental Hygiene.

Baltimore, Maryland 21215-0020

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Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Physician/Medical Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. py Completed 25. Wea case referred to medical exeminer? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 50 Netural 5 Pending investigation 1 Yes 2 No 2 Accident or Attendation of the death 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospitai
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 Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es steted. Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner ateted. 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Dete filed (Month Day, Year)

Osler

Sente 32. Registrer's Signature

30. Name end eddress of person who completed cause of death (ttem 23s) (Type, Print)

Md. 21284 Towson

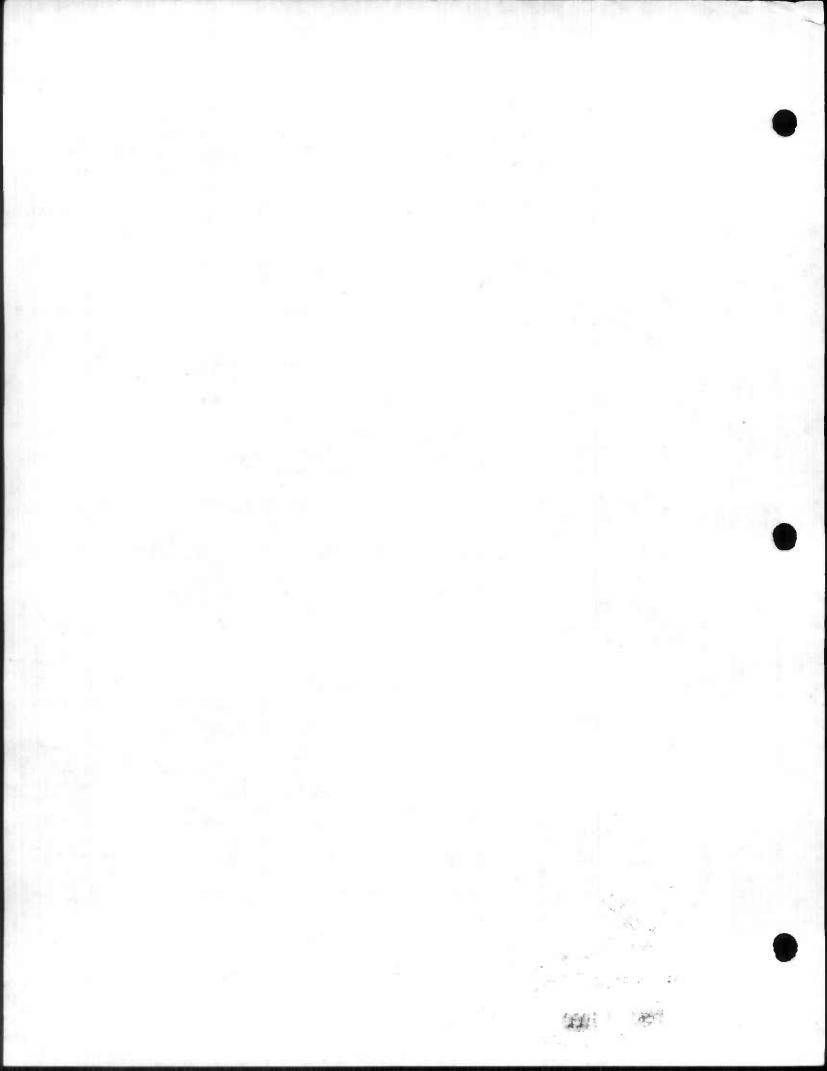


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	AMEND I	TEM: #31 PER V.R.	State of Marylan G778 12-1					nd M		giene	9	37639
	Physician	1. Decedent's Neme (First, Middle, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medical	ISABEL L. WH	TE			41	b. City. Toy	wn, or Lo	NOV .	29 199 4c. County		1:25pm
	Examiner	39 ACORN CIRCLE					rows	-		BALT		RE
	Funeral Director	5. Social Security Number 6. Sex 166-07-3583	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Deta of Bird (Month, Da 06/15		9. Birth	place (State or Foreign ntry) NSYLVANIA
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	vith the Ma to 28a-fe be notified Director	10e. Street and Number			10f. Zip C	ode				10g. Citizen of V	What Cou	ntry?
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020	or he man		2. Was Decedent Ever in U, Armed Forces? 1 Yes, 2 No If Yes, Give Year or Detes:		13. Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2010 No Specify:			gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	Specify	e - American Indian, k, White, atc.	
215-0020	led within 72 hours bygiene. The then "natural", It, the thedies Ex.	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual (kind of work DO NOT use	Occupa done d	ition uring most	of worki	ing	16b. Kind of Bu	usiness/In	dustry
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	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Finel disease or condition resulting in death)	Chronic	,	t/uc.					~	rese	Approximate Interval Batween Onset end Deeth
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Division	tal or Attending P re char death. al Director: After ti led in by the funeri Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Year) 28e. Place of Injury - At ho	Injury	М	1 🗆 Y	? /es 2 f	No				el Route Number,
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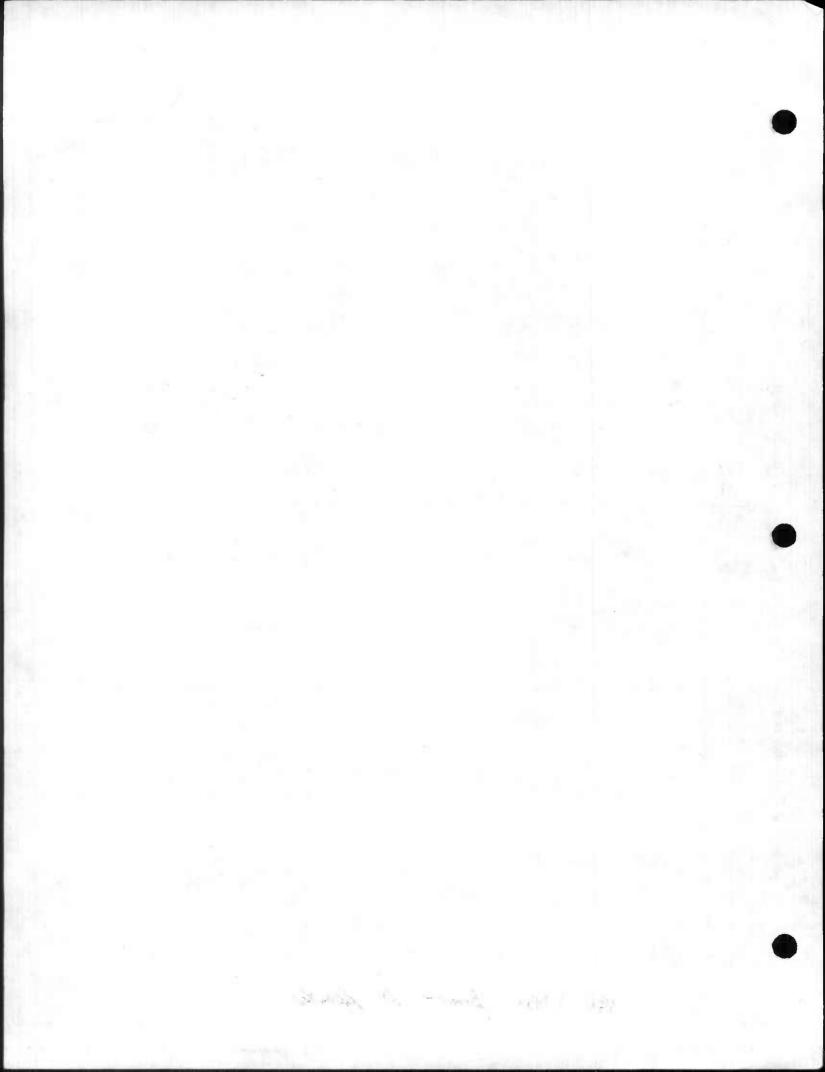
99-7084-510 RONALD WATSON

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State of Maryland / Department of Health and Mental Hygiene

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P			Certificate of	Death	Reg. I	No.	3/640				
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/Medical Examiner	48 Facility Nama (II not institution, give st MARYLAND SHOCK TR	treet and number)		4b. City, Town, or Loca BALT IMORE	ation of Death	4c. County of Death	1:30 A				
Funeral Director	Social Security Number 6. Sax		birthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs.	B. Date of Birth (Month, Day, Yes	N/A 9. Birth 45	placa (Stata or Forei				
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al', or herrs 23a or 28a-1 shor Examiner must be notified at by Funeral Director	11. Marital Status 11. Nevar Married 2 Married	2. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 No If Yas, Give Year or Datas:	13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spec ban, Mexican, Puerto Ri Specify:	ify Yaa or No- ican, atc.)	14. Race - Ameri Black, Whita, Specify: B) A					
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世 世	LEONARD WATSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Cod										
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P S	20a. Method of Disposition	20b. Place	of Disposition (Name of terry, crematory or other plants			Location - City or T	00				
17 Or 11	1 Burial 2 Cramation 3 Re 4 Donation 5 Other (Specify)	emoval from Stata METR	^		29-99 B	ALTO, MO).				
mportant: ny injury fice.	21. Signatura of Funaral Sinvica Licensed		22. Nama and Addr CREMATION	ess of Facility	~ 1110						
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2 should	96				24a. Was an au performed	? ar	Vara autopsy finding vailable prior to ompletion of cause of death?				
cate he					19 Yes	2□ No 1	ØYes 2□ No				
irector, per o Be Co	25. Wes casa rafarred to medicat axaminar?	ospital:	0	26. Place of Deeth other:							
E -	1 No 27. Mennar of Death	1X Inpatient 2 LER/	Outpatient 3 DOA Time of 28c. Injury We	4 ☐ Nursing Hom	a 5 ∐ Rasidence d. Describe how in	6 □Othar (Speci njury occurred	ity)				
al Director: After led in by the funering Certification:	1 Natural 5 Pending 2 Accident invastigation 3 Suicide 6 Could not be	(Month, Day Year) 11-26-99 28a. Place of Injury - At home,	1645M 10	Yes 2 ₽No	SUSTELL	and Number or Rui	rel Route Number				
Illed in by	4 7 Homicide datamined	building, etc. (Specify) Smooth			City or Town, St.	W. F	anothe s				
To the Funeral Directory filled in the Medical Certi	29a. Certifiar (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowled or: On the busined axamination a and manner stated.	ige, death occurred at the t and/or investigation, in my	ima, data and place, an opinion, death occurred	d dua to the cause d at tha time, date of	i(s) and manner as and place, and due	stated. to the cause(s)				
To the company	29b. Signatura and titla of certifiar	911	29c. Licen	M.E		Data signed (Month) VEMBER 27					
29	30. Nama and addrass of person who com		a) (Type, Print)								
State	31. Data filed (Month, New, Year) 1 10	100 32. Registray's Signature		in Street,	Baltimore	, Maryla	nd 21201				
State	11176	199	~ juju								



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State of Maryland / Department of Health and Mental Hygiene 99 3764

		C	ertificate of	Death		Reg. No.					
	Decedent's Name (First, Middle, Last)				2. Dete of De		3. Tima of Deeth				
Physician		١	NIEBO	JER	Novem.	Dey Yes	999 10:55AM				
/Medica Examine	de Englis Mana (Mana landa de ala ala ala ala ala ala ala ala			4b. City, Town, or I							
Examine	JOHNS HOPKINS HOSPI	DV		BAITIMAN	6 1101						
Funeral		Age (In yrs. last birthda		BALTIMOR If Under 24 Hrs.	8. Date of Birt (Month, Da	th 9.1	Birthplace (State or Foreign				
Director	195-38-7838 12 M 2□F	53 Yrs.	Months Davs	Hours Min.	Novem	y. Year) ber7.194	6 Pennsylva				
	Usual Residence of Decedent				10000	.,.,.	- remisjiva				
Man Man	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits				
Man de la company de la compan	Virginia Fairfax	1 1 1 1 1	Alex	kandria			1 ☐ Yes 2 ◯ No				
or 28a-f s	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?				
A S S S S S S S S S S S S S S S S S S S				22309		II C A					
uffer death with the Menylen r Herre 23e or 28e-f show niner must be notified at	8758 Old Colony Way 11. Merital Stetus 12. Wes Decede		3 Wes Decedent of		pecify Yes or No	U.S.A	merican Indien,				
Her of	1 Never Married 2 Married 1 XYes 2		Wes Decedent of If Yes, specify Cult	oan, Mexican, Puert	Rican, etc.)	Black, W					
d within 72 hours at plans. Than "netural", or the Mades Learn.	If Vac Gue	os? □N°65-69 os: 75-79	1 ☐ Yes 2 ☑ No	Specify:		Specify:	White				
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should it				A and Mumber on Du	-	Kennedy	a Zin Cadal				
~ ~ ~ ~ ~						er, City or Town, Stet	22309				
C = 0 N	Coleen Wiebner 20a. Method of Disposition	875	8 01d Co	olony Wa	y Apt.	1 - A Alex 20c. Location - City	andria, VA.				
8 5 2 0	1 Burial 2 Cremetion 3 Removel from Sta	compleas of	remetant or other nic	ece)							
Pa and: ury	4 Donation 5 Other (Specify)	E.Harr	isburgC	rematory	11/30	Harrisbu					
pemit. Page Department of Important: if any Injury or DRSE.	21. Signature of Funeral Service Licensee		22. Name end Addr	ess of Fecility Ma	rzullo	Funeral	Service				
22528	muchael & marsullo	100					aryland2115				
	23a. Part1. Enter the disease, or complications that cau	sed the death. Do not					Approximete Intervel Between				
Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.										
/Medical	Immediate Cause (Final	C		1			0				
Examiner	disease or condition resulting in death) a. 000	Due to (or as a con:		TWM OL	(Atr)	SEVE	1 4 MONTH				
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a a a a a a a a a a a a a a a a a a a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	200 10 (01 03 0 001	sequence ory.								
death certificate be assocuted eathording physician and of for use as the bufal-transitional formula f	Ceuse (Disease or Injury that initieted events	Due to (or es a cons	and all								
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FEE	NON HODGKIN	2 64	mp 1to m	A	10	Yes 20 No	1 Yes 2 No				
ysician: The law is cartificate has be director, paga 2 s				26. Place of Dee	th (Check only o	ine)					
- > =	1 Yes 2 No Hospitel: 1 Map	atient 2 ER/Outpat	ient 3 DOA	ther: 4 Nursing H	ome 5 Resid	dence 6 Other (S	Specify)				
Phys a Phys		njury 28b. Time		ury et	28d. Describe I	how injury occurred					
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i or Attending after death. Director: After d in by the fune	3 Suicide 6 Could not be determined 28e. Plece of building	Injury - At home, ferm, etc. (Specify)	street, fectory, office		28f. Location (S City or Tox		r Rural Route Number,				
be or Attending P as after death.	Dulloning	etc. (Specify)			Oily Or 701	m, otare)					
To the Hospital or Attanding Ph Within 24 hours after death. To the Funeral Director: After thi completely filled in by the tuneral	29a. Certifier 1 Certifying Physician: To the be	st of my knowledge, de	eth occurred et the t	ime, date end plece	end due to the	ceuse(s) end menne	r es stated.				
he Hospif in 24 hour he Funer pletely fill	(Check only 2 Medical Examiner: On the basis	s of examinetion and/or	investigetion, in my	opinion, death occu	rred et the time,	date end plece, end	due to the cause(s)				
within 2 To the comple	29b. Signeture and little of continue		29c. Licen	se number		29d. Date signed (M	onth, Dey, Year)				
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M	MICHAEL BARICO J	H H 60	o W. wa	ings 2.	7, 15	ALTIMO	(12				
State	31. Date filed (Month, Day, Year) 1 32. Reg	istrar's Signature	19 100	uls							
Registrar	AFA 7 1004 1										

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JOHN WALDHAUSER AMEND ITEMS: #23 PART I, 27, PER MEO Certificate of Death

State of	Maryland A	/ Department of	Health and Menta	I Hygier
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	Funeral Director
5-0020	72 hours after death with the natural', or flams 23a or 29 sical Examinal must be not
Maryland 2121	od 2 should be filed within the and Mental Hyglene. 27 is marked other than "r r traumatic event, the Med
Baltimore,	permit. Pages t at Department of Hee Important: if Ihem; any injury or othe obes.
Baitimore, Maryland 21218	parmit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Medical pages.

Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death 0100 **Physician** John Michael Waldhauser NOVEMBER 26, 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death er 2316 POPLAR ROAD **ESSEX** BALTIMORE If Under 1 Year H Under 24 Hrs 8. Data of Birth (Month, Day, Year) Sept. 2, 1924 9. Birthplaca (Stata or Foreign Country) Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours M 20 F 75 Yes 218-14-8456 Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. Baltimore 1 ☐ Yes 2% No Essex 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 21221 2316 Poplar USA Road Funeral 14. Race - American Indian, Bleck, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Nama (First Middle Last) 8 John S. Waldhauser Tina J. Roubal 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Rita Harris- Sister 4807 Sunbrook Ave. Baltimore, Md. 21206 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, State 1 2 Burial 2 Cremation 3 Removal from State Holy Redeemer Cemetery 11/30/99 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Gary R. Di Giovanni 22. Name and Address of Facility Leonard J. Ruck Funeral Home 5305 Harford Rd. Baltimore, Md. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on sech line. Approximata Intarval Batwe Onset and Death Physician ATHEROSCLEROTIC CARDIOVASCULAR DISEASE & CIRRHOSIS OF Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P

physicien and s the buriel-transit The lew requires that the death certificate be executed Box 68760. P.O. Records, Completed 95 ed of Vital ial or Attending Physicien: The sher deeth.

al Director: After this certificate ed in by the funeral director, pr 8 edical Certification: To Division filled in by

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Ware autopsy lindings available prior to completion of causa of death? 24a. Was an autopsy 1 Yas 2 No 1 □ Yas 2 □ No 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA XXYes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28l. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier

18

To the Hospital within 24 hours a To the Funeral Completely filled

Registrar

MARIARIM 31. Data filed (Month, Day, Year) DEC 0 1 1999

P. COREC My 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

NOVEMBER 26, 1999

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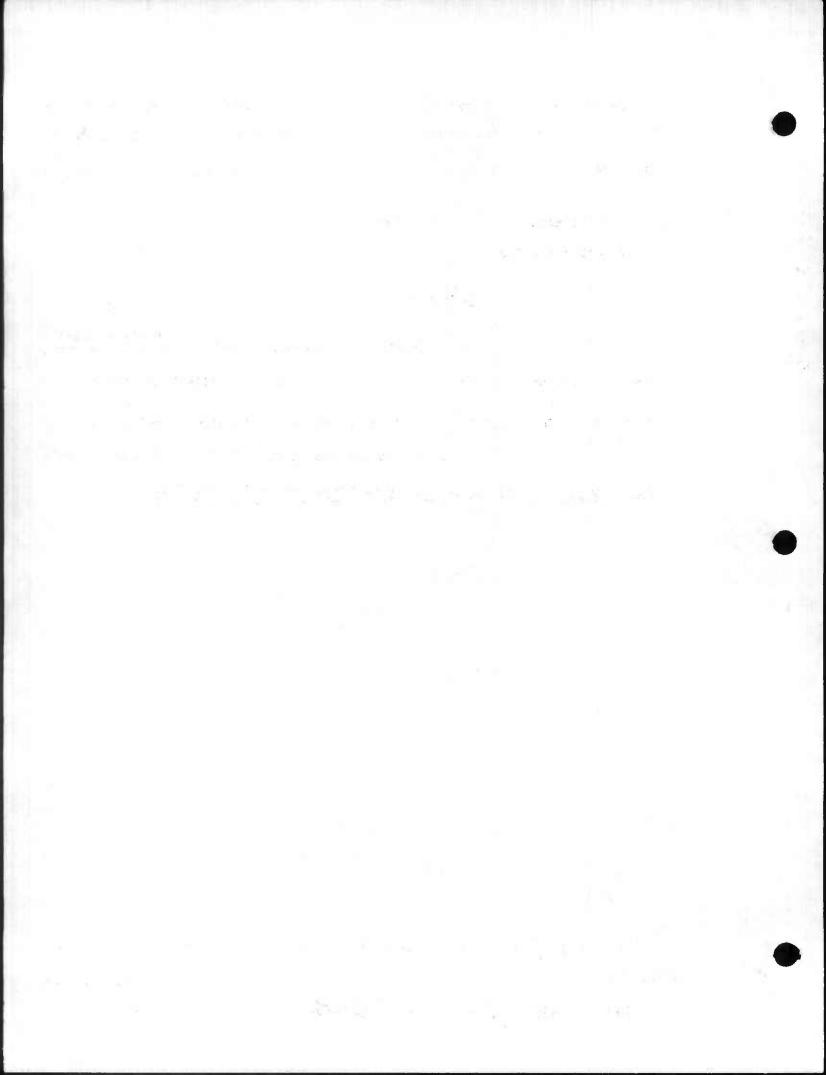
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death Month Dey Year **Physician** James Ronald Zarfoss 09:00 AM /Medical 4e. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Center Baltimore If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 5 Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foraign Country) **Funeral** 1☑M 2□F Days 217-24-4998 Yrs. Director 11-29-1929 70 Pennsylvania Usuel Rasidance of Decedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Timonium 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? r then "netural", or items 23s or the Medical Examiner must be a 207 Coldbrook Road 21093 U. S. A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritel Status Rieck. White, etc. filed within 72 hours after 1 ☐ Yas 2 ☐ No If Yas, Giva Yeer or Detes: 1951-1955 1 Nevar Married 20 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Environmental Elementery/Secondary (0-12) Collaga (1-4or 5+) Director Of Research & Development-Elements Corp. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Sumama) Be Pages 1 and 2 should be 1 sent of Health and Montal I int: If Item 27 is marked of Clarence Raymond Zarfoss Margaret Elizabeth 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mrs. Myrna E. Zarfoss (Eife) 207 Coldbrook Road, Timonium, Maryland 21093 20b. Place of Disposition (Nama of cematery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Dete Buriel 2 Cramation 3 Ramoval from Stete Dulaney Valley Mem. Gards. 12-2-99 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Nama end Addrass of Facility Vallace S. Brook, in Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** METASTATIC CARCINOMA OF THE LUNG /Medical Immediata Causa (Final diseasa or condition rasulting in daath) 6 MONTHS Examiner Dua to (or es a consaquance of): physician and is the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in death) Lest Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 8 950 signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Waa an autopsy performed? certificate Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica 25. Was casa rafarred to medical axaminer? 26. Placa of Death (Check only one) axaminer? Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Magnar of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Invastigetion 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and mennar as stated.

Madical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifian Medical (Check only one) within 2 To the 29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Dey, Year) naturidad D. de Leon, m. D. D 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) NATIVIDAD D. DELEON, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State DEC 1 1999

Registrar



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier@ Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** NOVEMBER Dey 29, 1999 Joseph F. Bonarrigo Sr. 10:40 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthpleca (Stata or Foreign Country) 6 Sax 7. Aga (In yrs. lest birthday) **Funeral** 18 M 2□ F 88 065-10-8494 Yrs Director November 21,1911 Mayland Usual Residence of Decedent 10e Stata 10b County 10c. City, Town or Location 10d. inside City Limits ed other than "natural", or items 23s or 28s-f shore event, the Medical Examinar must be notified at Harford 1 Yes 2 No Director Fallston 10e. Street and Numbe 10g. Citizen of Whet Country? 10f. Zip Coda Road Suttidae 21045 2.W 0 Funeral Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, Biack, White, etc. filed within 72 hours after Hygiene. ther then "netural", or its 1 Nevar Merried 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dales: 1□ Yes 2⊅ No þ Specify: White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Carpentary College (1-4or 5+) self-employed 10 semit. Pages 1 and 2 should be filed Department of Health and Mental Hygi reportant: If Hem 27 is marked other altimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Be Bonarrigo atherine Shepis Nunzio 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2226 Rutlidge Rd. Fallston, manyland 21047 Susan Thoupas-daughter 20b. Plece of Disposition (Neme of cematary, cremetory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 ⊠Buriel 2 □ Cremetion 3 □ Removel from Stata ö Dec.2, Parkwood Cemetery 1999 Baltmore, M 22. Nome and Address of Fability Evans Charles of Memore & 8800 Mayford Road 81236 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, maryland 21. Signature of Funerei Sarvice Licensee DO. aun Baltimore, maryland 21234 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physiclan** PNEUMONIA /Medical Immediate Cause (Final diseesa or condition resulting in death) Examiner Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner physician and s the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760, 8 Physician/Medical Due to (or as a consequence of): atten Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t STROKE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed peed ate hes t 1 ☐ Yas 2 🕱 No 1 ☐ Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

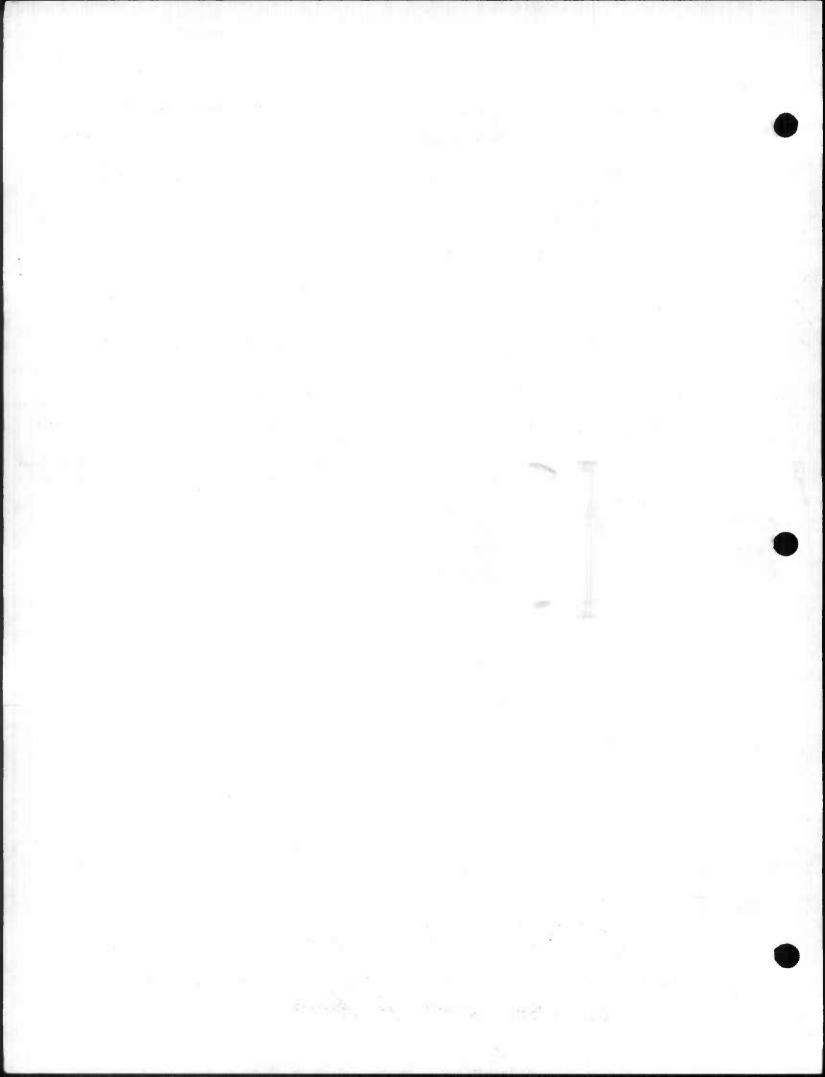
To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case refarred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) J. 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 5 Pending investigation 1 DeNaturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the ceuse(s) end menner es stated. 29a. Certifler 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signetura and title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) D 37254 30199 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 1999 32. Registre's Signeture

Souls

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Dev. Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 9 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month **Physician** Mary Becker

4e Facility Name (If not institution, give street and number) NOVEMBER 30, 1999 cation of Death 4c. County of Death /Medical 4b. City, Town, or Location of Death **Examiner** HOS p. ta 900 Caton AVE. Baltime

M. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

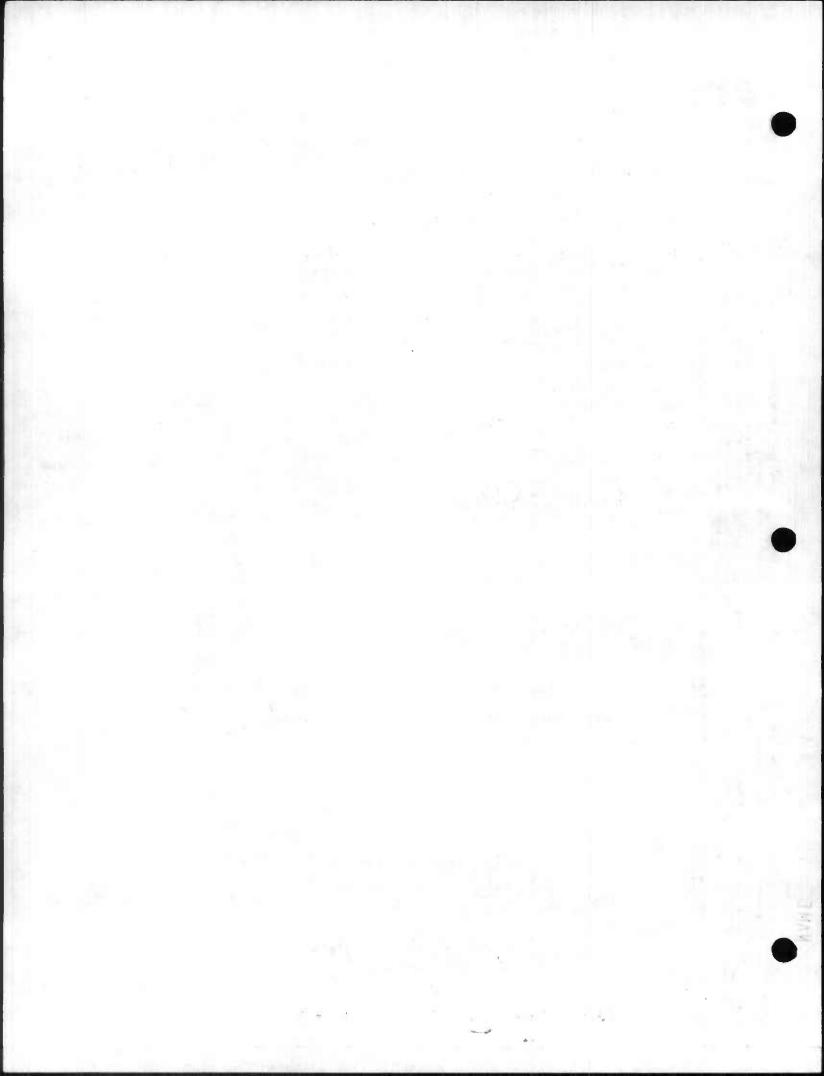
Months Days Hours Min. Asnes Baltimore Jaint 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) May 22, 1905 Maryland Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2♥F 94 214-26-8617 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f ahow Examiner must be notified at 1. Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3521 Falls Road 21211 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indian, Black White etc. 72 hours after 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 natural, or 1 Yes 2√No Specify: Specify: þ White 3)(Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Black and Decker Packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumstic eventone. Be 0 Samuel R. Emge Amanda Francis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Louise Frederick Daughter 4353 Newport Avenue Baltimore, Maryland 21211 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stele 4 Donetion 5 Other (Specify) Moreland Memorial Park 12/3/99 Parkville, Maryland 22. Name end Address of Facility 21. Signature of Fu Service Licensee Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland let the mode of dying, such as cardiac or respiratory arrest. m 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart ailure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final Preumonia 3 weeks disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in deeth) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Upper Gastrointestinal Bleeding duodend bleeding 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Dementia 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes this 27. Menner of Death 28d. Describe how injury occurred 28b Time of 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation after death. Director: Af 1 TYes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of parson with pleted cause of deeth (Item 23a) (Type, Print) Hospital Bellinore, ND. Michae 110 Saint MO 31. Dete filed (Month, Dey, Year) 2/ Registrar's Signeture State Same DEC Registrar

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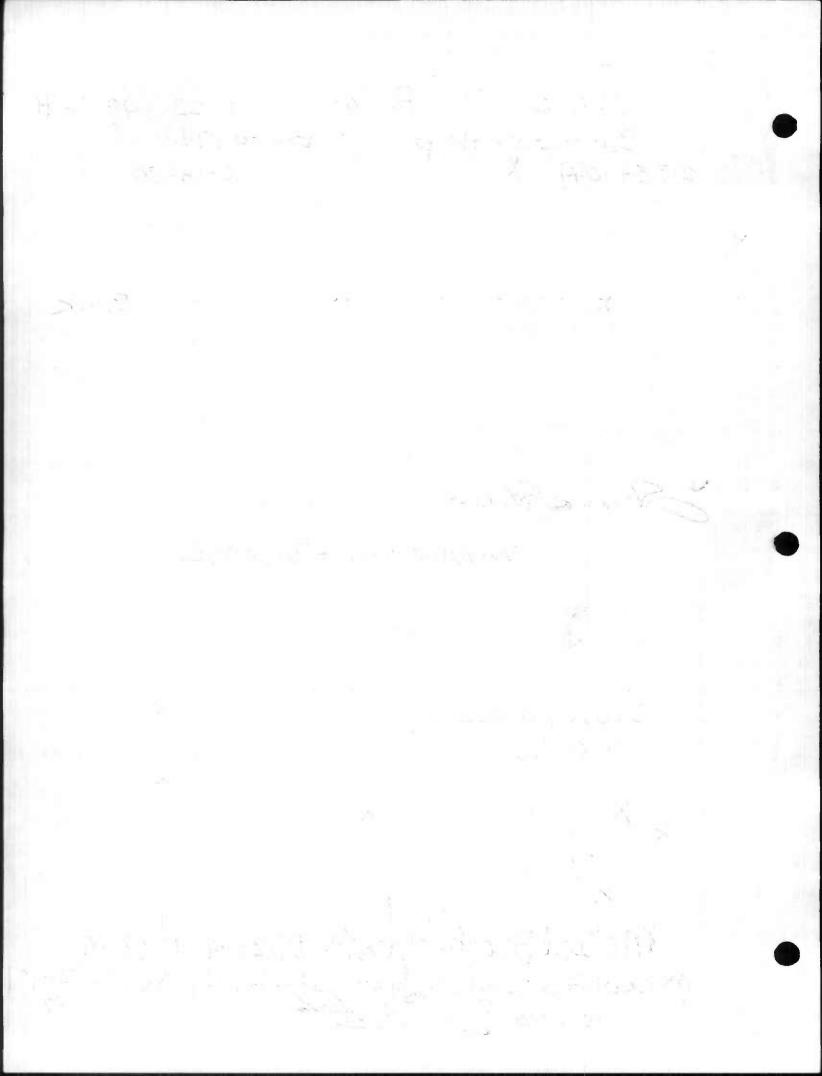
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #1 PER MD G778 12-2-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death VALARIE BAILEY **Physician** Month /Medical 4e. Facility Name (If not institution, giva street end numbar) 4b. City, Town, or Location of Death Examiner salto, 054 200 If Undar 24 Hrs. Hours Min. 6. Sax If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) Months Days 5 Yrs Director Usual Residence of Dacedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md permit Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylai Department of Heelth and Mental Hysiene.
Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show the future or other treumstic event, the Medical Examiner must be normed and Baltimore NA 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3502 Avenue 21216 5. A owhatan Completed by Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detas: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Induatry Battimore Federal College (1-40r 5+)
34ears Elementary/Secondery (0-12) President 12th grade Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Brad ley Latayette Juanita 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) - Mother 5406 Balto, Md 21215 Wabash Juanita 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Randa 11-27-99 Calvary 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Jarch F. H. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heert failure. List only one cause on each line. Wabash Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last the buriel-tran Due to (or es e consequence of): or Attending Physician: The law requires that the deeth certificate be exec Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): or: After this certificate hes been signed by the e the funeral director, page 2 should be deteched t Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? heave knowld 1 Yes 2 No 3 Probably 4 Unknown Medicai Certification: To Be Completed by Sorcoidosis 24e. Was en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? After this certificate 2 No 1 ☐ Yes 2 ☐ No. 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours e the Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date end place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifian 29c. License number 29d. Dal signed (Month, Day, Year) 30. Name end address of person who eth (Item 23a) (Type, Print) 31. Date filed (Month, Dey, 32. Regist State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death Month **Physician** WeatherfordNovember 25 19990215 (AM Byrd Virginia /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Union Mem. Hospital Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Funeral Days Hours Min. 1□ M 21XF Yrs. Director 06 577-56-9274 Usual Residence of Decedent 81 O.H. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumetic event, the Modical Examinet must be notified at 1 Yes 2 □ No Director Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1040 Deer Ridge Drive 21210 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: by 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade
17. Father's Name (First, Middle, Last) Balto City Schools 4yrs + Teacher 18. Mother's Name (First, Middle, Meiden Surneme) h end Mental I James Byrd Grace Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health e Important: If item 27 is any injury or other trac Grace Park Johnson-Daughter 4108 Westview Rd.Baltimore Md 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2XX remetion 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 12/01/99 Baltimore, Md 21. For ature of Funeral Service Ocensee 22. Name and Address of Fecility March F/H West 4300 Wabash AVe, Baltimore Md death. Do not enter the mode of dying, such es cardiac or respiretory arrest, 21215 f1/Enter the disease, or complications that cause ock, or heart failure. List only one cause on each Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Very Wmonon Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of) 80 9SD 0 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificata has 25. Was case referred to medical examiner?
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2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Juncen Folginson, M.)

30, Name and address of person who completed cause of death (from 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

Weatherford Virginii Baltimore, Maryland 21215-0020

certificate be executed

Box 68760

State

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31. Dete filed (Month, Dey, Year)

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32 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene O

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	1		TIMOTHY LOW, M	.D 7601	OSLE	R DRIL	/E,]	POWSON,	MARYLA	AND		
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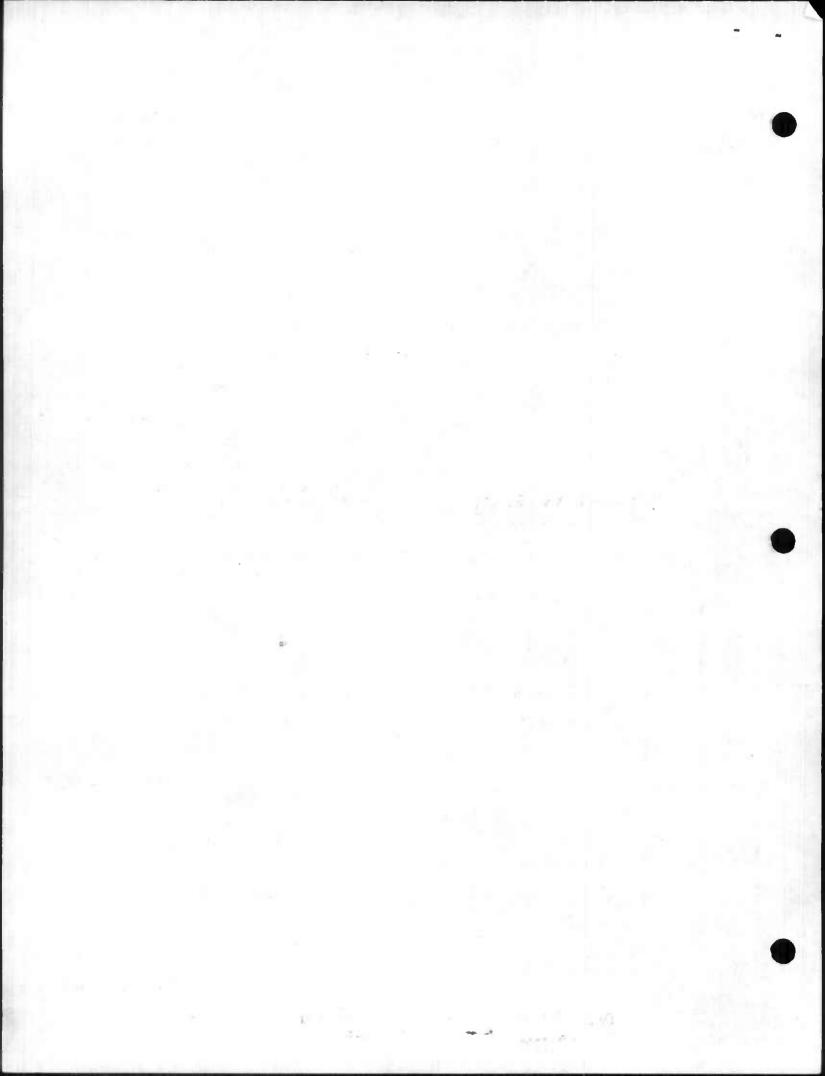
DHMH 16 Rev 6/95

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Dete of Death 3. Time of Death **Physician** NOVEMBER Park . 14999 Marie M. Davis 9:45 AM /Medical 4a. Facility Name (If not Institution, give street end number)
Saint Joseph Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Center Towson 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** Months Days 1 M 2 F Hours 217-20-2043 Yrs. Director December 1,1927 Maryland Usual Residence of Decedent 10a. State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A 21234 Avenue 2333 oster 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian. 11. Meritat Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, atc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker Department of Health and Mental Hygis Important: If Item 27 is marked other t any injury or other to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Williams Benjamin Margaret Schnabel 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) homas Davis-Son 2622 Evergreene Ave Baltmore, IMD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stete Dec-3, 4 Donation 5 DOther (Specify) Baltimore, maryland 1999 Moreland Mem. Park 21. Signature of Funerel Service Licansee 22. Name and Address of Fecility Evans Enaper of memories
8800 Harford Road
Baltimore maryland 21: 21234 eather 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CARDIAC TAMPONADE /Medicai Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of):
STATUS POST ADRITC VALVE REPLACEMENT Examiner siclan and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physiclan s the burial P.O. Box 68760. 2 Physician/Medical The law requires that the death certificate Due to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. detached 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 Yes 2 No COAGULOPATHY Records, à 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? peen RENAL FAILURE completion of cause of death? has page 1 Yes 2 No certificate 1 ☐ Yes 2 XNo Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th Certification: 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier Medical To the Vithin 2 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) W 31826 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RICHARD L. LINTHICUM, M.D., 76@1

OSLER DRIVE, TOWSON, MARYLAND 21204

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month DEC Cear) 2

32. Registrar's Signature

1999

UH (128)

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Death Month **Physician** 4:00 Am DRAPER NOVEMBER 27, 1999 /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Avenue Harding Carne If Under 24 Hrs. 8 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplaca (State or Foreign Country) **Funeral** Min. Deys 1□M 20 F Months Hours 219-22-4060 Director JUNE 23, 1916 West Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show the Medical Examiner must be notified at 1 Yas 20 No Director Jaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 9615 U.S.A Avenue 238 arding 21234 death Rema. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Merital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 9 Specify: White 1 Yes 20 No Specify: à 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n School TEACHER Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens important: If Nem 27 is marked other that any Injury or other traumatic. Secretory

18. Mother's Name (First, Midgle, Maiden Sumema) Association 12 17. Father's Neme (First, Middle, Last) Be Cora tong allace alton uzetta 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9615 Harding Avenue Corney MD 21234 Gregory Uraper-20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) Dete Dec 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete Gardens of Baltimore Faith 4 Donation 5 Other (Specify) 1999 22. Name end Address of Fecility Evans Chapel of Memores 21. Signeture of Funerel Service License 8800 Harford Rd Baltimore, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata fntervel Between Onset and Death **Physician** carcinoma /Medical Immediate Ceuse (Final disease or condition resulting In deeth) Examiner Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and Due to (or es e consequence of): Physician/Medical the Due to (or es a consequence of) attending lor use as Box (signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, þ Completed 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? page 2 2 DINO certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: after death. Director: After this certific director. Be 25. Was case referred to medical axeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 8 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending 1 Yes 2 No 2 Accident invastigetion 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28a. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated. 29a. Certifier Descripting Physician: 10 file best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signatura and this of certified 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

York

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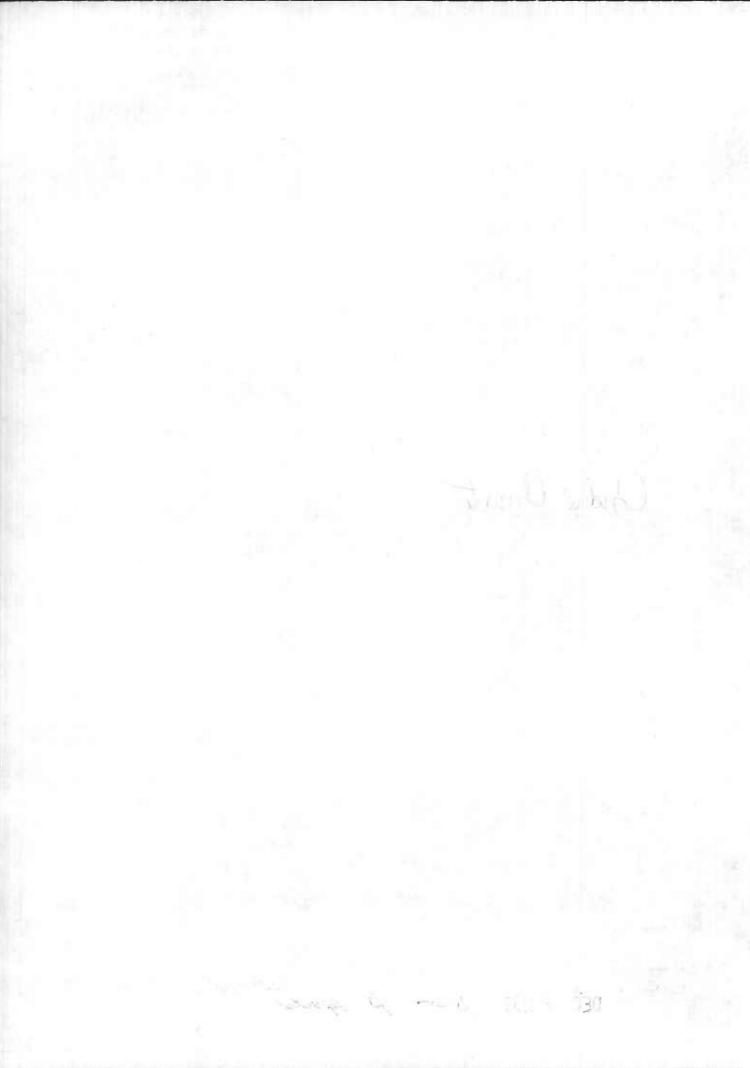
19992. Registral's Signatur

Road

Lutherville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death Month Turender a. Facility Name (If not institution, give street end riumbar) 4b, City, Town, or Location of Deeth BALTIMORE marion 617 7. Age (In yrs last birthday)
Yrs. If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 9. Birthplece (State or Foreign 0625 1 M 2 F 24 Usuel Residence of Decedent 10a. State 10b. Count 10d. Inside City Limits 10 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 1009 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) Raca - American Indien Bleck, White, etc. 1 ☐ Yas 2 No 1 Never Merried 2 Married 1 Yes 2 No Spacify: 3 Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired)

US OURSON 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other p 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removel from Steta 4 Donetion 5 Dother (Specify) 21. Signeture of F wal Service Lice disease, of complications that caused the deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrast, allure. List only one cause on each line. Intervel Between Onsat and Death 2 days Immediet Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicida 6 Could not be Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide

Physician /Medicai Examiner Division of Vital Records, P.O. Box 68760,

attending physician and for use es the buriel-tran signed by the a director this filled in by the funeral After death. or Attend after death Director: To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Physician

/Medical

Examiner

Director

by Funeral

Completed

Examiner

Physician/Medical

Completed

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29e. Certifier

Director

must be notified

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"natural",

Pages 1 and 2 should be filled nent of Health and Mental Hygis int: If larn 27 is marked other

altimore,

traumatic event, the Medical Examinar

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State Registrar

29b. Signeture end title of certifier

29c. Licanse number

1 A Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29d. Deta signed (Month, Day, Year)

187541 NOV 30, 99

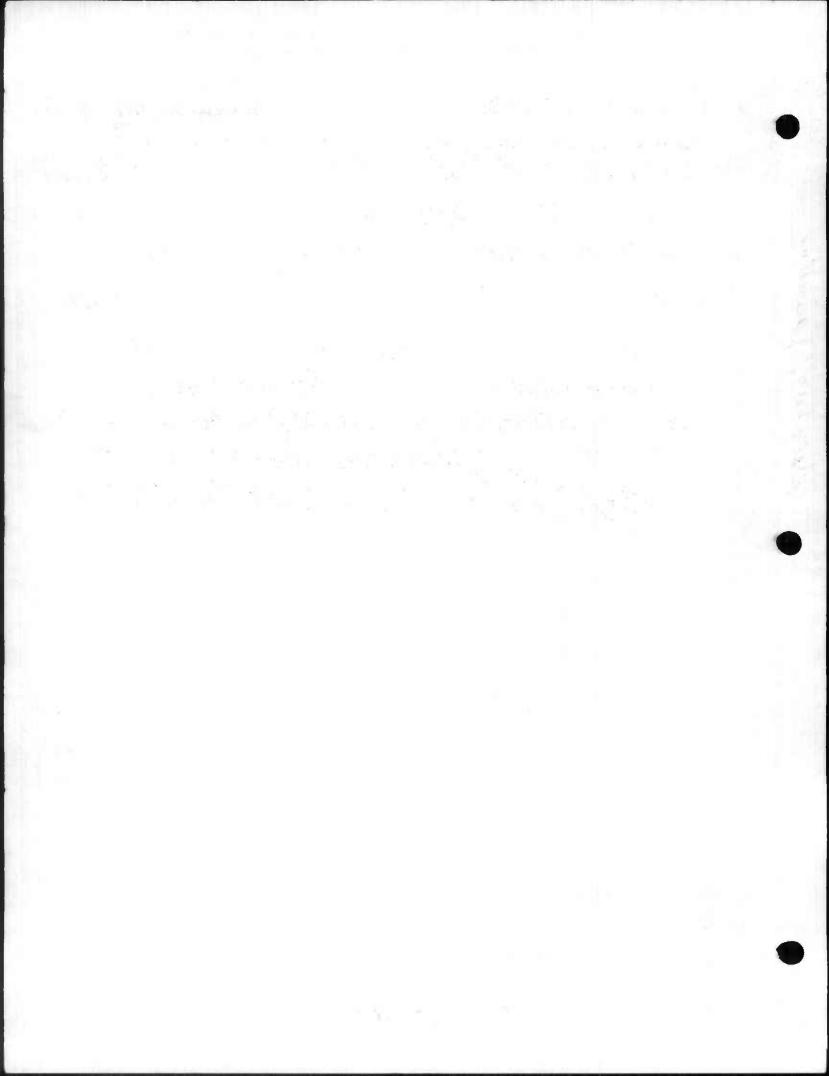
30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 4367

Fenny Rd, Belthiou, MD-21227

31. Dete filed (Month, Dey, Year)

32. Registrar's Signeture

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Dons treeburger November 24,1999 2:43pm /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital rederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF 215-14-818 Director June 25, 1923 mary land Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Frederick 1 Yas 2 No Director Frederick 10e Street and Number Apt 10f. Zip Code 10g. Citizen of What Country? ь must be U.S.A Lane 21703 flams 23a 5820 Gene Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, Whita, atc. 72 hours after 1 Never Merried 2 Married "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: À White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) School Bus Attendant d 2 should be filed w In and Mental Hygle 7 is marked other ti 10 Schools 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental His importants if them 27 is meany injury or other 86 Goeb DUIS JOSEPH Meister Marie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Frederick, MD 21703 5820 Genesis Lang. Apt SOI Martin E. Freeburger-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) NO4.27, Parkwood Cemetery Baltimore, Mayland 21. Signeture of Funerel Service Licensee

22. Name and Address of Facility Evans Chapel of Mundones

850 Harford Road

800 Harford Road

21. Signeture of Funerel Service Licensee

22. Name and Address of Facility Evans Chapel of Mundones

850 Harford Road

800 Harford Road

21. Signeture of Funerel Service Licensee

850 Harford Road

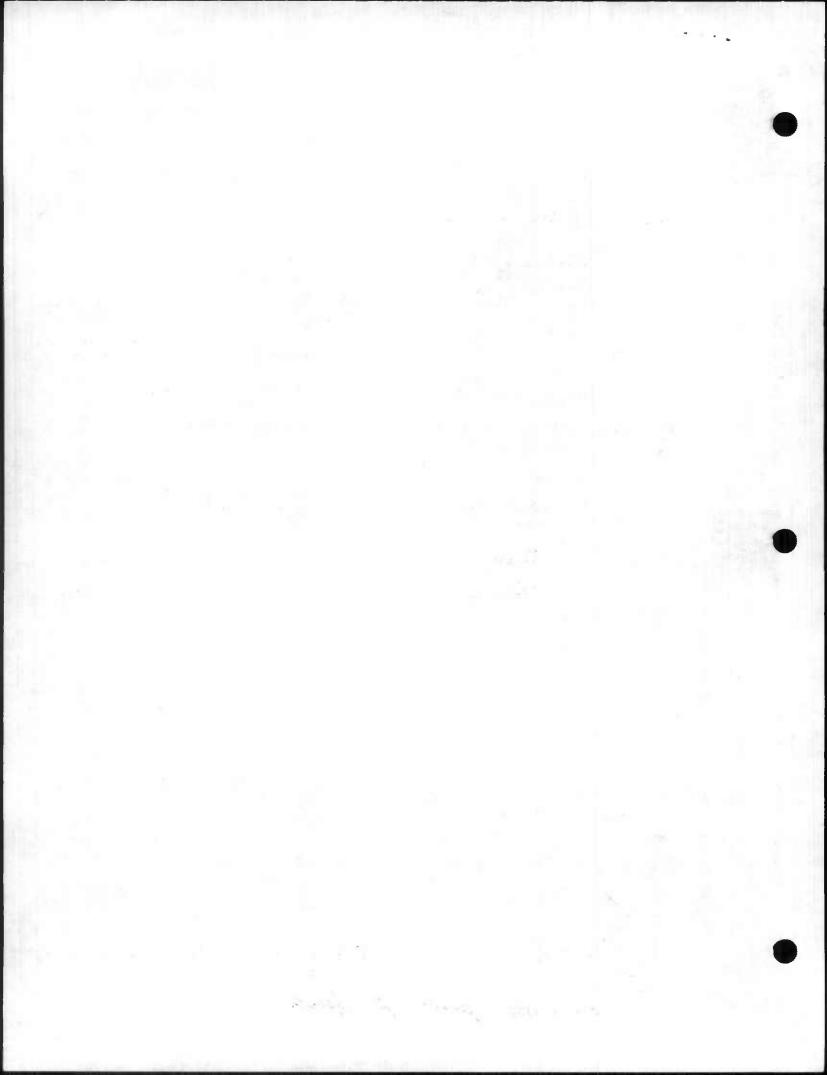
800 Harford Road 1999 21234 Approximete Interval Between Onsat and Deeth **Physician** /Medical Immediate Cause (Finel . TWEUMONIA 3 DAYS disease or condition resulting in deeth) Examiner Due to (or as a consequence of). Examiner ASCULITIS The law requires that the death certificate be executed physician and stranstrans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? the the signed by t 1 Yas 20 No 3 Probably 4 Unknown þ 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 s 2 KNO 1 ☐ Yes 1 ☐ Yes 2 No Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificaletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 28. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 250No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) 204 FREDERICK WARAYDEKAR 1475 LAWEY 1999². Registrary Signeture 31. Date filed (Month, Day Year) State

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Ray 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** Victor tarino 29,1999 2:40 Am Nov. /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Hospital Baltimore
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Baltimore 6000 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Birthplece (State or Foreign Country) 6 Sex **Funeral** 10XM 20F Months Deys 82 Yrs. Director 213-07-6743 maryland June Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Parkville 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6 21234 U.S.A 9642 Avenue Nems 23s mason Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 72 hours after 1 X Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: White p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.1 Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natu any injury or other traumatic event, the instruction." 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Bethlehem Steel College (1-4or 5+) Elementery/Secondary (0-12) Factory Worker 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Stephen Farino, Sr. Guercio Angelina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) 9642 mason Avenue Parkville, mb 21234 Constance Lively -daygliter 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete Dec. 2, 4 Donation 5 Other (Specify) Baltimore, maryland most Holy Redeemer 1999 22. Name and Address of Fecility Evans Chapel of memones 21. Signeture of Funeral Service Licensee 9900 Harford Kuad Baltimore, mo reather Ou mo 71234 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician fmmediate Cause (Final diseese or condition resulting in death) /Medical LING CANCER Examiner Due to (or as a consequence of): Physician/Medical Examiner CORONARY HOMET DISBASE the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last pue Due to (or es a consequence of): physician Box 68760. Due to (or as a consequenca of): 980 23b. Dfd tobacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by 1 Yss 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25KNo certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Menner of Death 1. Neturel 28b. Time of Injury 28c. Injury at Work? 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred or Attending 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted. Medicai 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29 1995 30. Name end address of person who completed cause of deeth (ttem 23a) (Type, Print)

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DHMH 16 Rev 6/95

State

Registrar

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31. Date filed (Month, Dey, Year)

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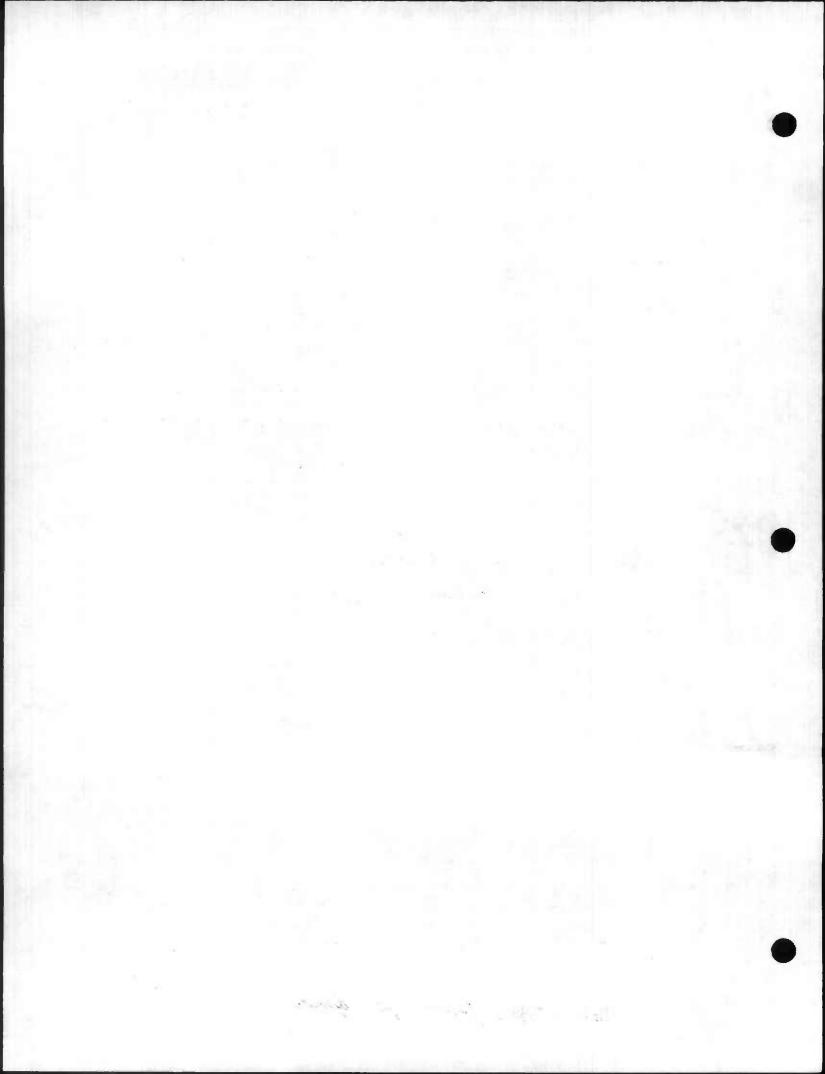
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32. Registra/s Signature

Lock Raver Blad, Balt 4d21235



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ~ Reg. No. 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death **Physician** Norman Fieldon Farris November 29, 1999 1:48 p.m. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holabird Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Stete or Foreign Sept. 10, 1935 West Virginia 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 GM 20 F Yrs Director 215-30-6052 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Dundalk 1 ☐ Yes 2 X No Maryland Berra 23s or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늄 7291 Holabird Avenue 21222 U.S.A. Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 20 No
If Yes, Give
Yeer or Detes: natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: Specify: White 3 Widowed 4 X Divorced Completed permit. Pages 1 and 2 should be fised within 72.1 Department of Health and Mental Hygiene. Important: if then 27 is marked other than "restuany finjury or other traumatic event, the Medical 2005. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9 Motorcycle Sales Salesman 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Garner Walker Farris Macil Lilly 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna Freund (sister*) 1818 Elk Road, Baltimore, Maryland 21221 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stele Dulaney Valley Mem. Gard. 12/3/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Bruzdzinski Funeral Home, P.A. 29s. Part Lifer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Arrhythmia Immediate Examiner Due to (or as e consequence of): Examiner SC.V.D physicien and s the burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): 88 The lew requires that the death P.O. 1 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown signed b Records, b 24b. Were eutopsy tindings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy page 2 s has 2 No 1 Yes 2NNo 1 ☐ Yes certificate Division of Vital Hospital or Attending Physician: 24 hours after deeth. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 28b. Time of After 5 Panding investigation 1 Neturel 1 Yes 2 No To the Hospital or Attendit within 24 hours after deeth.

To the Funeral Director: All completely filled in by the fu 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Cartifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of periffi 29c. License number 29d. Dete signed (Month, Day, Year) 301 142232

DHMH 16 Rev 6/95

State

Registrar

2/12 Dundalk Ave.

32. Registrar's Signature

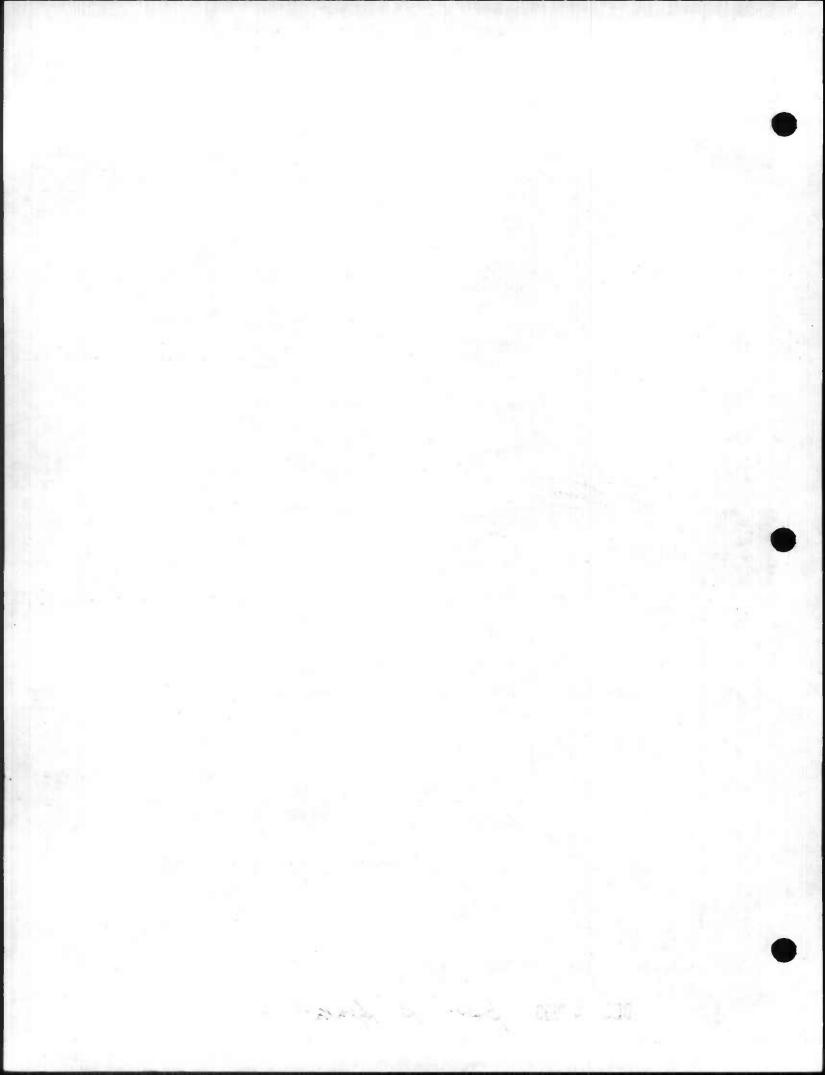
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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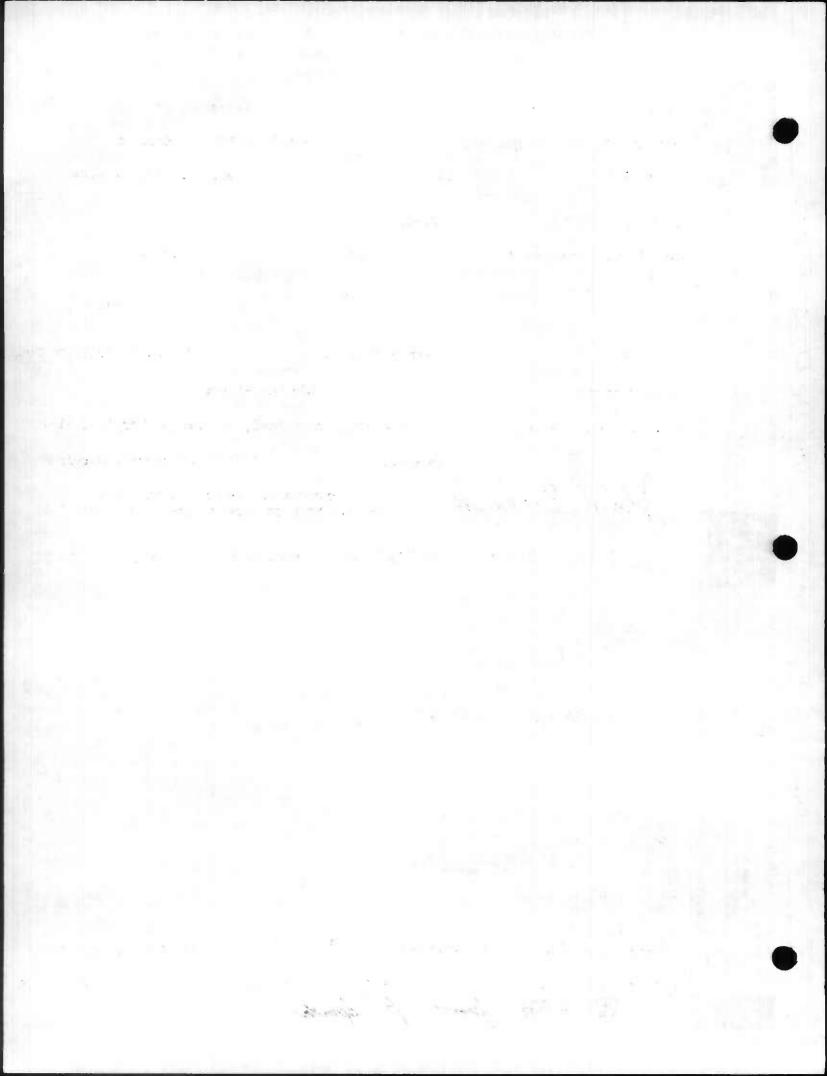
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31. Dete filed (Month, Dey, Year) DEC 2



		State of Maryland	Certificate o	of Death		leg. No.	37657				
	1. Decedent's Name (First, Middle, Las	st)			2. Data of Dea	0	3. Time of Death				
Physician /Medical	William Kelso I	Freyer			DECEMBE	R 01 1	999 0703				
Examiner	4a Facility Name (If not institution, give			4b. City, Town, or Le	ocation of Death	4c. County					
	Harford Memorial		Williams V	Havre De		Harfo					
al or	220 10 3973	7. Aga (In yrs. I.	est birthday) If Under 1 Your Months Da	ear If Undar 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day Dec. 1	Year) 1, 1925	9. Birthplace (State or Foreign Country) Maryland				
	Usual Rasidence of Dacedant 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits				
Director	Maryland Cecil	Col	nowingo				1 ☐ Yes 2 ☐ No				
Directo	10e. Street and Number		10f. Zip Coo	de	1	I0g. Citizan of V	Vhat Country?				
	753 Liberty Grove	Road	2191	18		U.S.A.					
Funeral	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexicen, Puerto	ecify Yes or No-		e - Americen Indian, kk, White, etc.				
by	1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yas 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2X		ritoan, etc./	Specify					
e de	15. Decedent's Ed	ducation	16a. Dacedant's Usual Od	ccupation	ha	16b. Kind of Bu	usiness/Industry				
nple	(Specify only highest gra	Collaga (1-4or 5+)	lifa. DO NOT use ra	one during most of work atired)							
Completed	12		Owner Operat			Hardware, Building Su					
Be	17. Father's Name (First, Middle, Last)					Maiden Sumam	10)				
6	William Freyer 19a. Informant's Name/Relationship (Time (Print)	19b. Mailing Address (St.	Ada Mae		City or Town	State 7in Code)				
To Be C							aryland 21918				
	Mary R. Freyer (W. 20a. Method of Disposition	20h Pi	ace of Disposition (Name of	of	Date Date		City or Town, State				
eny injury or e	1 XBurial 2 Cremation 3 4 Donation 5 Other (Specific	Mailloval Itomi State	metery, crematory or other y Rosary		2/4/99	Raltimo	re, Maryland				
à	21. Signature of Funeral Service Licen		22. Name and Ad		2/4/99	barcino	te, rarytara				
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sician edical miner	23a PMP . Enter the disease, or composition or haart failure. List only immediata Causa (Final disease or condition rasulting in death)	a CHRONIC OI									
bunal-transit	Sequentially list conditions, If any leading to immediate Dua to (or as a consequence of):										
<u>e</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C									
n/Medic	that Initiated events resulting in death) Last	Due to (or	as a consequence of):								
N. C.		d									
/ Physician	D. All Other levision and the	The state of the s	Maritan de distribuir	and the Park I	005 0144						
y Physician/Medical	Part II. Other significant conditions of	RY TUBES	e givan in Parti.	23b. Did tobacco usa contributa to the cause 1 Ves 2 No 3 Probably 4							
Completed by P					24a. Was a perfor	an autopsy med?	24b. Were autopsy findings available prior to completion of cause				
orector, page 2.					1 🗆 Y	es 2 No	of death?				
	25. Was casa referred to medicel			OR Disease of Decision			ILITOS ZULMO				
To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3 DOA	Other: 4 Nursing Ho	ome 5 Resid		er (Specify)				
	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time ot 28c.	Injury at Work?	28d. Dascribe h						
atio	1			Work? 1 ☐ Yes 2 ☐ No							
Certification:	3 ☐ Sulcida 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ma, farm, straat, factory, off	fice	28f. Location (S City or Tow	Street and Numb m, State)	per or Rural Route Number,				
completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	viedga, daath occurrad at th ion and/or invastigation, in r	ne tima, data and place, my opinion, death occur	and dua to tha dred at tha tima, d	causa(s) and ma data and place,	annar as stated. and dua to the cause(s)				
To the Funeral Director: After completely filled in by the funer medical Certification:	29b. Signature and titla of certitier	/	29c Lic	cense number		29d. Date signe	d (Month, Day, Year)				
01	AM) avant	W ER ATT	ENDING 1	40356	7	DECEMBER OI 1999 HAVRE DE GRACE 21078					
V	30. Nama and addrass of person who	completed causa of death (Item	23a) (Type, Print)								
,	WENEUSA NA	VARRO, MD.	501 50.	UNIONA	VE-HA	NRE DE	EGRACE 21078				
State	31. Date tiled (Mort) P.P. Year 2 1	999 32. Registrar's Signat		ash.							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 2. Date of Daath 1. Decedent's Nama (First, Middle, Last) Month Day Yaar November 30 1999 Freddie Fowler 12:00PM Lee 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death | DUITGAL... | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Country) | Sept. 2 1931 | Virginia 57 Shipping Place Apt. B-16 6. Sex 1 ☐ M 2 ☐ F 5. Social Security Number 7. Aga (In yrs. lest birthdey) Birthplaca (Stete or Foreign Country) Months Yrs. 244-38-7297 68 Usuai Residenca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Md. Baltimore Dundalk 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 57 Shipping Place 21222 Apt. -B-16 U.S. of America 12. Was Decedant Ever in U,S. Armed Forces? 12 Yes 2 □ No If Yes, Give Yaar or Dates: 14. Race - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) NA Elementary/Secondary (0-12) Maintenance Lutheran Church 18. Mother's Nama (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) Lucille George Fowler Bullington 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sylvia Hafer (Daughter) 4130 Maple Path Circle Balto., Md. 21236 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dec. 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 22. Nama and Addrass of Facility W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., culions that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. 23aL Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Deeth immediate Ceuse (Finel disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Cardiomyopas Ischemic Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Kegurgi tation 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 22 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show eny Injury or other treumatic event, the Medical Examinet must be not the temporary.

Baltimore, Maryland 21215-0020

Examiner ettending physician and for use as the buriel-trensit Physician/Medical signed by the e p been si Completed certificate has t lirector, page 2 s

Be

Certification: To

Medical

25. Was case referred to medical	
exeminer? 1 ☐ Yes 2 ☐ No	Hospitai:
27. Manner of Death	28a. [

5 Pending Investigation 1X Natural 2 Accident 3 ☐ Suicide 6 Could not be determined 28a. Date of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29a. Certifier

4 Homicide

TE Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

29b. Signature and title of certifian

0005 1148

December 1, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Baltimore, 3701 Eastern 31. Date filed (Mg)/E

State Registrar

32. Redistrar's Signature

To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this cartifice completely filled in by the funeral director, i

and the same of th and the real of the contribute the fraction of the contribute the

page 2 director, this funeral After

of Vital or Attending Physician: Medical Certification: To

Division within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Hospital ŝ 0

State

29b. Signeture and title of certifier 42

DEC

5 Pending

investigation

6 Could not be

25. Was case referred to medical

XXYes 2 No

27. Menner of Death

1 Neturel

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

28a. Dete of Injury (Month, Day Year) 11-29-99

ar

29c. License number

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

unithown

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

O.C.M.E

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

28c. Injury at Work?

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, Mill City or Town, State) Lock Raven Dr., Morgan

Selfinflicted gunshot wound

Baltimore County, Maryland

1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE

28d. Describe how injury occurred

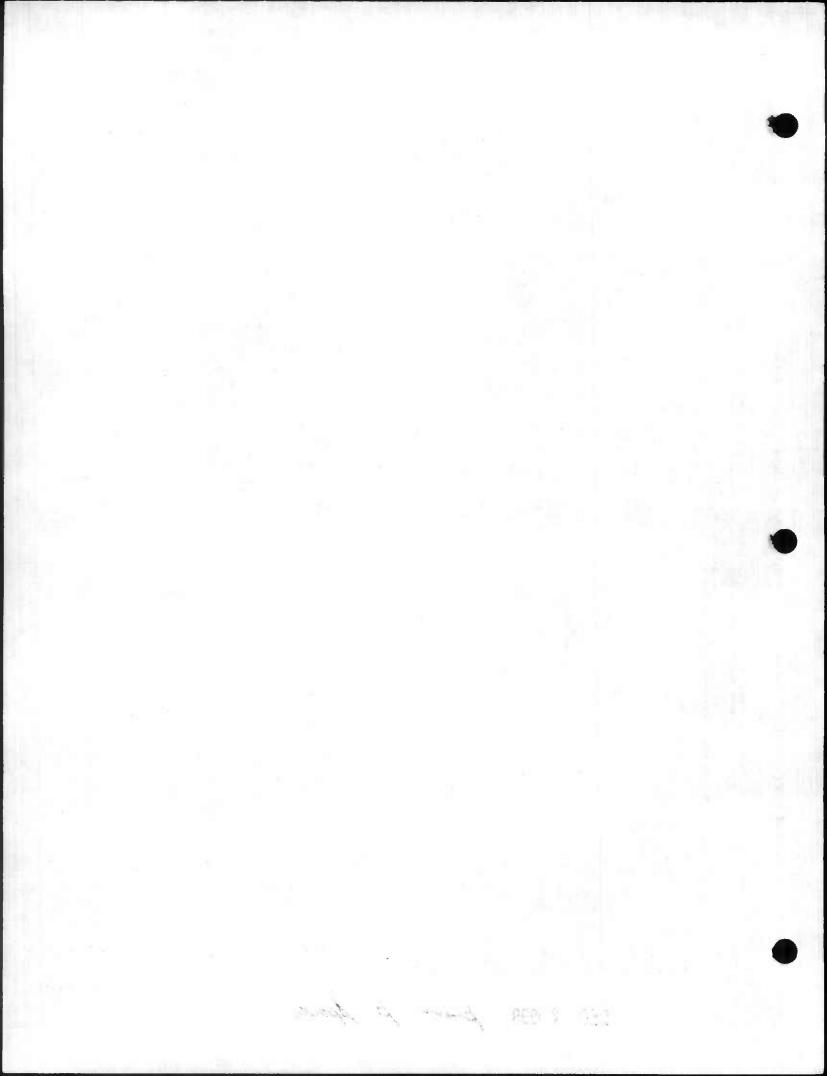
NOVEMBER 29, 1999

30. Name and address of person who completed cause of death (Item (Type, Print)

1999 >

Stephen S, 31. Date filed (Month, Day, Year) Radentz, 111
32. Registrer's Signeture Penn Street, Baltimore, Maryland, 21201 oaks

Registrar DHMH 16 Rev 6/95



Piease Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year **Physician** MARGARET ELEANORE BRENT GROVE November 30, 1999 1:03 AM /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5810 Merville Avenue Baltimore N/A If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 X F Yrs. 213-38-9178 Director 89 Feb 23, 1910 | Pennsylvania **Usual Residence of Decedent** with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Director N/A Baltimore City 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 5810 Merville Avenue 21215 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Berra. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Merried b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White à 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Retail Department Elementary/Secondery (0-12) College (1-4or 5+) Bridal Consultant Store 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 ahould be fit timent of Health and Mental H tant: If them 27 is marked off lury or other traumatic ever Be 10 Margaret Ellen Walters John Albert Brent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5810 Merville Avenue, Baltimore, Maryland 21215 William C. Grove (Son) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdns12/3/99 Timonium, MD 21093 Funeral Services 22. Name and Address of Facility awson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ariest. Mary 1 and 21212 approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical tmmediete Cause (Final disease or condition resulting in deeth) Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasl Bud Due to (or es a consequence of): Box 68760, Physician/Medicai the Due to (or as a consequence of): USB 85 signed by the atte Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 BNatural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide filled in by 4 - Homicide Hospital 24 hours a 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ae 30. Name end address of person who completed cause of youth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

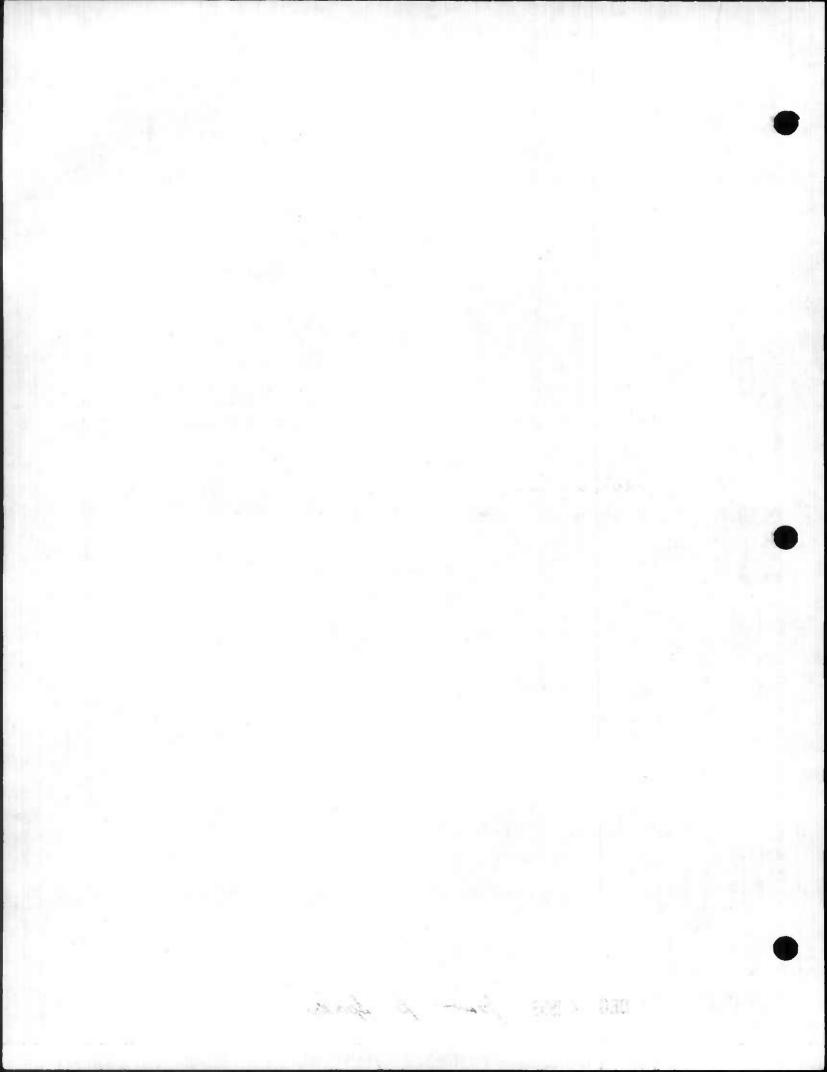
5601 Loch Raven Blvd., Baltimore, MD 21239

Padgett,

M.D.

32. Registrar's Signature

Charles A.



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

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uneral		5. Social Security Number 6. S		e (In yrs. last birthday) If Under		If Under 24	0.00	ta of Birth onth, Day, Ye		9. Birthplace (State or Foreign Country)		
rector		219-39-8883	Ø1 2 □ F	6 Yrs.	Months	Days	Hours	Min. Sep	onth, Day, Ye	1993	Country) IM D		
or frame 23s or 28s-f show		Usual Residence of Decedent 10a. Stata 10b. County	•	10c. City, Town or L							10d. Inside City Limits		
nouthe	Director	MD Ba (+) 10e. Street and Number	imore	rar	KVI 11e		-		10g.	Citizen of W	1 ☐ Yas 2 ဩ No What Country?		
i	Za D	34 Hyacin	th Rd				234			US	A		
	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑1 If Yas, Give Year or Detes:		Was Deced If Yes, spec		ispanic Origin n, Mexican, I Specify:	n? (Specify Yo Puerto Rican,	as or No- etc.)		e-American Indian, k, White, atc. "White		
	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5	(Giv		or of the control of	during most o ()	of working	16b	Kind of Bu	usiness/Industry		
-	To Be C	17. Father's Name (First, Middle, Last) William F.	Hamel				18. Mother's	Nama (First	Middle, Maio Kues		a)		
		19a. Informant's Name/Relationship (1) William + Usa +	1 /			4	and Number			y or Town, MD	Stata, Zip Code) 2-12-34		
		20a. Method of Disposition 1. Burial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of Disp cometery, cre Garde	matory or o	Fa.	ith	Dec-	3 R	osed	ale, MD		
STORES		21. Signature of Fundral Service Licen	3 abl	Ve ?							chapel re MD 21234		
n		23a Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each li	10.	itar tha mod	e of dyin	g, such es ca				Approximate Interval Between Onset and Death		
ai er		Immediate Cause (Final disease or condition resulting in death)	a. Kecu	VVENT W		tu	mor				le wks		
	Examiner		b. Wilm	is tum							Zyrs 8 mo		
	M M												
	Physician	Part II. Other significant conditions of	ontributing to death b	ut not resulting in tha	underlying c	ausa giv	en in Part I.	2	3b. Did tobac	- 4	ntribute to the cause of death?		
	Dy Pu								1 🗆 Yes	2D/No	3 Probably 4 Unknow		
	Completed						-	24	la. Was an ai performed	itopsy	24b. Were autopsy findings available prior to completion of cause of death?		
	멀							15 110	17 120	2 12 No	1 ☐ Yes 2 ☐ No		
		25 Was case referred to medical	axaminer? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou 27. Manner of Death 1 ☑ Netural 5 ☐ Pending Respond to the second of the second					ma of 28c. Injury at 28d. Dascribe how injury occurred jury Work?					
	0	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Netural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tima			yat k? Yes 2 ∐ No	0					
director, page	0	axaminer? 1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ry Year) 28b. Time (Injury)	of M	1 🗆		28f. Lo	cation (Street by or Town, St	and Numb tate)	per or Rural Route Number,		
ocus of the luminal anactor, page 2	Certification: 10 Be	examiner? 1	28a. Date of Inju (Month, Da) 28a. Place of Inju building, etc	ry Year) 28b. Tima Injury ury - At home, farm, so. (Specify) of my knowledge, dea axamination and/or is	M 2 Mireet, factory	1 □ r, office at the tin	Yes 2 □ No	28f. Lo	e to the cause	tate) e(s) end me			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death **Physician** NOVEMBER 30, 1999 Emory L. Huber. Sr. 11:40 AM /Medical 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Baltimore Towson 8. Data of Birth (Month, Dey, Year) Jan. 24, 1908 7. Aga (In yrs. lest birthday) | If Undar 1 Yaar | If Undar 24 Hrs. | Months | Days | Hours | Min. 5. Sociel Sacurity Number 6. Sax Birthpiaca (Steta or Foraign Country) **Funeral** Months 10XM 20F 212-07-0255 91 Director Maryland Usuei Residance of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic svent, the Med cal Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Oliver Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U.S.A. 13119 Rivervan Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detes: 14. Reca - Amarican Indian, Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic avant, the Medical Exercised once. Bleck, White, etc. 1 ☐ Navar Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: White. þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 8th Grade. College (1-4or 5+) Warehouseman Storage Company 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John Huber Laura (surname unknown) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Mrs. Sandra Huber (dghtr-in-law) 33 Watergreen Lane, Ocean Pines, MD 21811 20b. Pieca of Disposition (Neme of camatery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurlei 2 □ Cramation 3 □ Removel from Steta 12/4/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 22. Name and Addrass of Facility
Schimunek Funeral Home, Inc. 21. Signeture of Funerei Service Licenses lee 9705 Belair Rd., Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** 24 HOURS /Medicai immediate Cause (Finei disaase or condition resulting in death) SEPSIS Examiner Due to (or es e consequence of): Examine physician and the burial-transit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequance of): Box 68760, Physician/Medical Dua to (or as e consequança of): 88 attending use a for Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 signed by ti PERIPHERAL VASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown þ been signal 24e. Wes en eutopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed page 2 s 2 No 1 Yes 2 No 1 Yes certificete or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitei: 1 inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? After To the Hospital or Attending within 24 hours effer death.

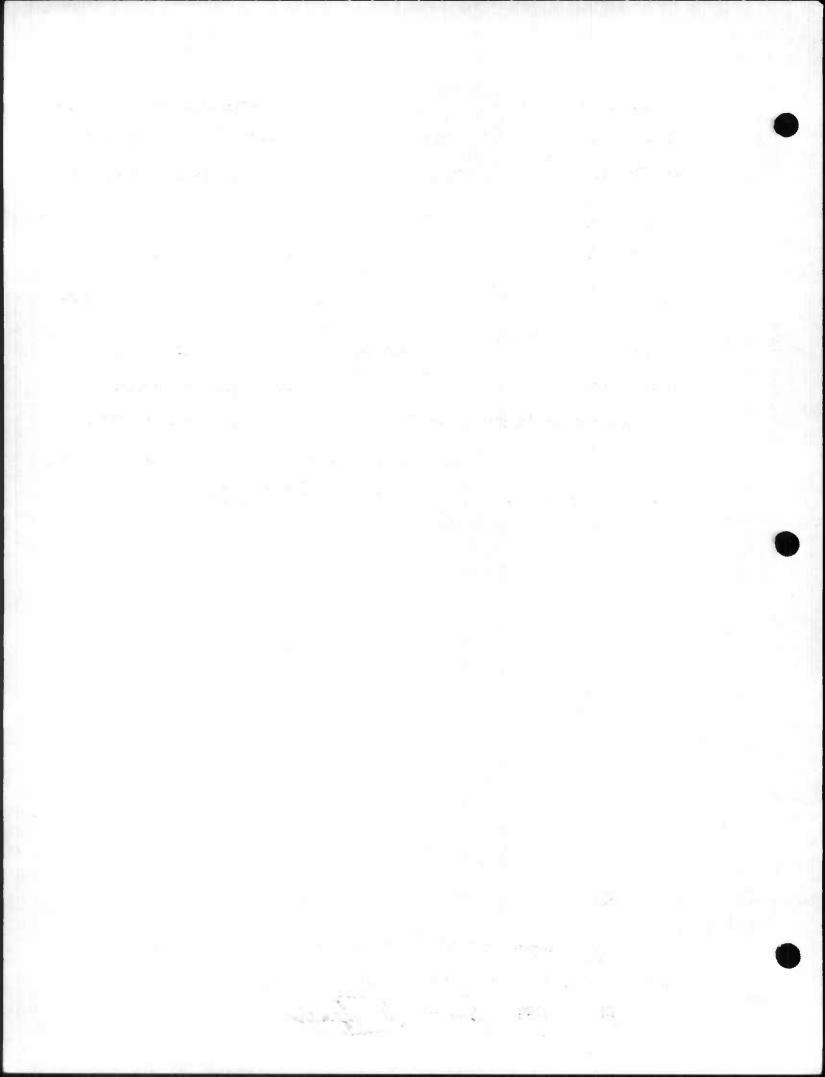
To the Funeral Director: Afte completely filled in by the fune 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident invastigetion 6 ☐ Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end mannar stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D30263 11-30-99 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO M.D.7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State 1999

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37663 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Graham Martin Harman, Jr. November 30, 1999 5:50 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9011 Tammy Road Baltimore Baltimore 8. Data of Birth (Month, Day, Year)
June 21, 1938 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F 216-36-6655 Yes 61 **Director** Maryland Usual Rasidenca of Decedant 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9011 Tammy Road 21236 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours eiter to Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Hedical Esampha Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: White Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Aerospace Defense Accountant 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Graham Martin Harman, Sr. Warfield Lenora 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9011 Tammy Road, Baltimore, MD Mrs. Nancy H. Harman (wife) 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cramation 3 ☐ Removal from Stata Gardens of Faith Cemetery 12/3/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensee Wil a. 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner Examiner 'o na arten physician and the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disease or Injury that inditated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of) signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobecco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Conknown Division of Vital Records. Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 22 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was casa retarred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manper of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation Natural 2 Accident 1 Yes 2 No 6 Could not be datarmined 3 Suicide 28e. Place ot Injury - At homa, tarm, street, tactory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 4 Homicida To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

Registrar

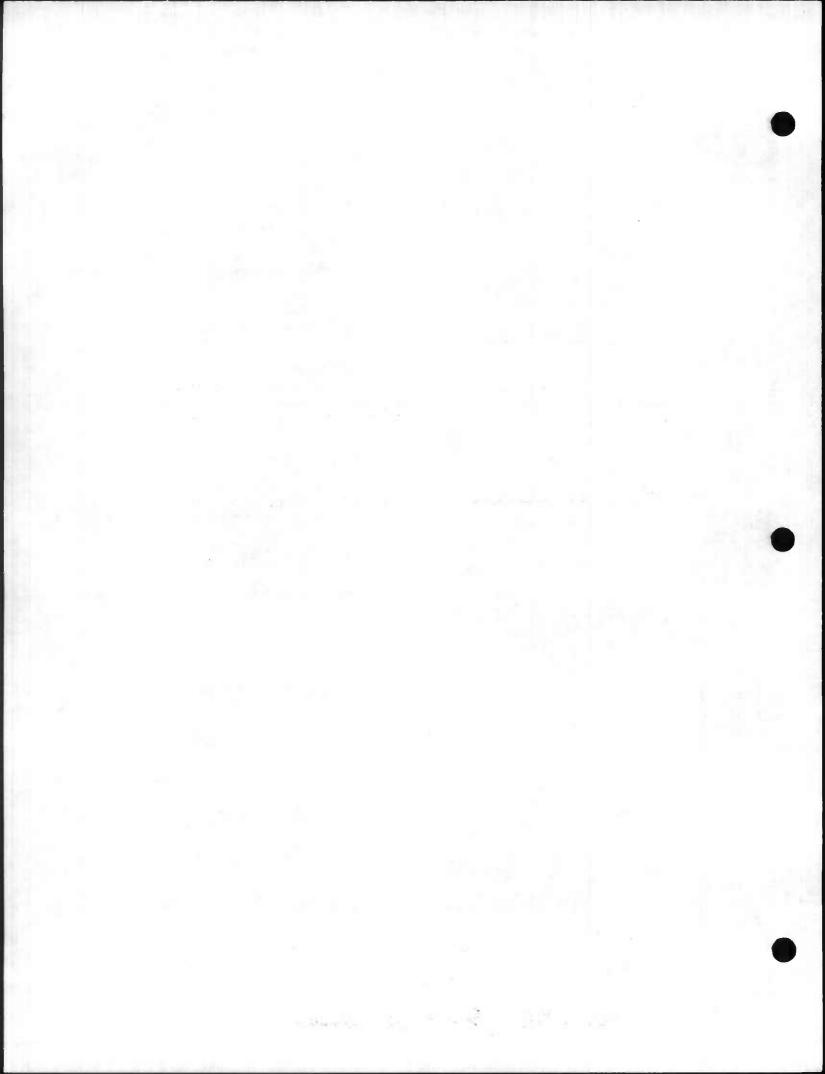
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30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

31. Data filed (Month, Day, Year)

Dr. Jeffrey Cool, 9712 Belair Rd., Baltimore, MD

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middla, Last) 2. Data of Death NOVEMBER 29, 1999 **Physician** ALICE HESSIAN 12:50PM /Medical 4s Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHN'S HOPKINS BAYVIEW MEDICAL CENTER BALTI MORE
If Under 24 Hrs. 8, Date 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2XF Months Days Hours Min. 216-12-8512 Director Maryland Usual Residence of Decedent 10e State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or hams 23s or 28s-f show other traumeds event, the Medical Exeminar must be notified at 1 Yas 2 No Maryland N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 S. Ellwood Ave. 21224 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yas, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pagas 1 and 2 should be filled within 72 hours after of Department of Hasith and Mentel hygiene.

Department: if item 27 is marked other than "natural", or han eny injury or other traumatic event, the Medical Exercition pages. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: white à 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 apartment manager real estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Edward Alan Underwood Marian Elizabeth Rowe 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Cherokee Lane Kathy Deavers/niece Bel Air, MD 21015 20n. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 Donalion 5 Other (Specify) Greenmount Crematory 12/2/99 Baltimore, Maryland 22. Name and Addrass of Facilit Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, MD 21212 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) PNEUMONIA one week Examiner Dua to (or as e consequence of) Physician/Medical Examine physicien and the buriai-transit The lew requires that the deeth cartificate be executed Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or es a consequence of): Box 68760. Dua to (or as a consequence of) USB 88 1 23h. Did tohecco use contribute to the cause of death? Records, P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown hypernatremia, Coronary artery disease, dementia, Š 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Chronic obstructive pulmonary disease 1 Yas 2 No of Vital or Attending Physician: 25. Wes casa referred to medical examiner? 8 26. Placa of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpalient 3 DOA this After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Netural 2 Accident To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun. 5 Pending investigation 1 Yes 2 No 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

State
Registrar

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Johns Hopkins Baywew Medical Center

NOVEMBER, 29, 1999

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Elizabeth Pynadath

of parson who completed cause of death (Item 23a) (Type, Print)

1999^{32. Registrat's Signature}

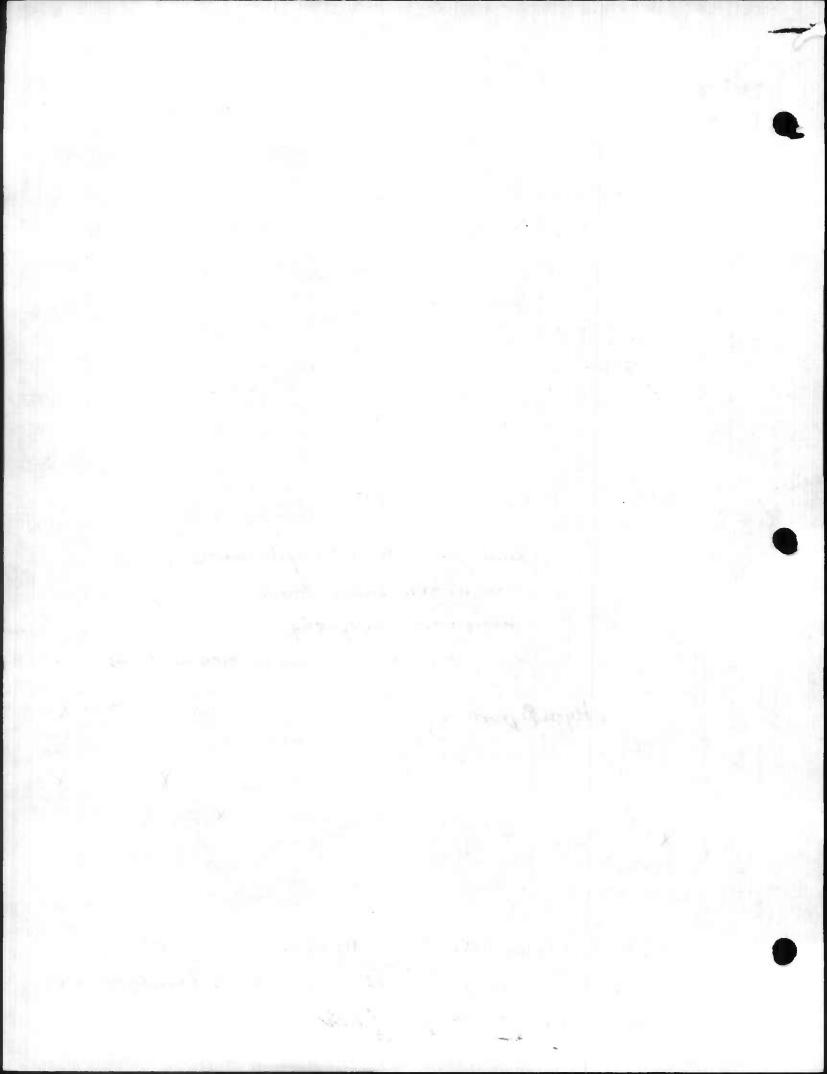
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Physician/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Severe	to (or as a consector to (or as a consector)	quence of): Quence of):	Aley			seaf	•	
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THE	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	28f. Location (S City or Tox	8f. Location (Street and Number or Rural Route Number, City or Town, State)						
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Medical Certification: 7	29b. Signatura and title of certifiar	The state of the s		29c. Licens	e number		29d. Date signe	d (Month, Da	y, Year)	
	David J. f			129	7928		12/	1/99		
State	30. Name and addrass of person who co	ompleted cause of deeth MM MO 32. Registrar's 5	36356	Print) Old Ct	RL Suit	E610.	Pikesvill	le MO	21208	
gistrar	DEC 2 1999	Baner	19	Soorka	/					

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 16:40 PM Samue₁ 1999 Lowberg 24 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore
If Under 24 Hrs. 8. D
Hours Min. (A If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 100 M 2□ F Months Days Yrs. 82 Nov. 19,1917 Massachusetts 015-12-8795 Usual Residence of Decedent 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits YYes 2□ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 625 Hubner Street 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? X(X) Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: WW I I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Window Assembly Mill Works 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Samuel A. Lowberg Jeanette E. Corliss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Marilyn Hubbard Daughter 6311 Roebud Road, Stedman, North Carolina 28391 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest MD VA 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/30/99 Garrison Forest, MD 5 ☐ Other (Specify) 4 Donation 21. Signature of Faneral Service Licansee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a Part Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bowel Disease weeks disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 2 weeks ena Due to (or as a consequ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 M Probably 4 ☐ Unknown Aortic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 250 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1₺ Inpatient 2□ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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Certification:

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29a. Certifier

Baltimore, Maryland 21215-0020

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Hospital or Attending Physician: 24 hours after death.

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Year) 1999

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29b. Signature and title of certifie

East University 32. Registrar's Signature

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

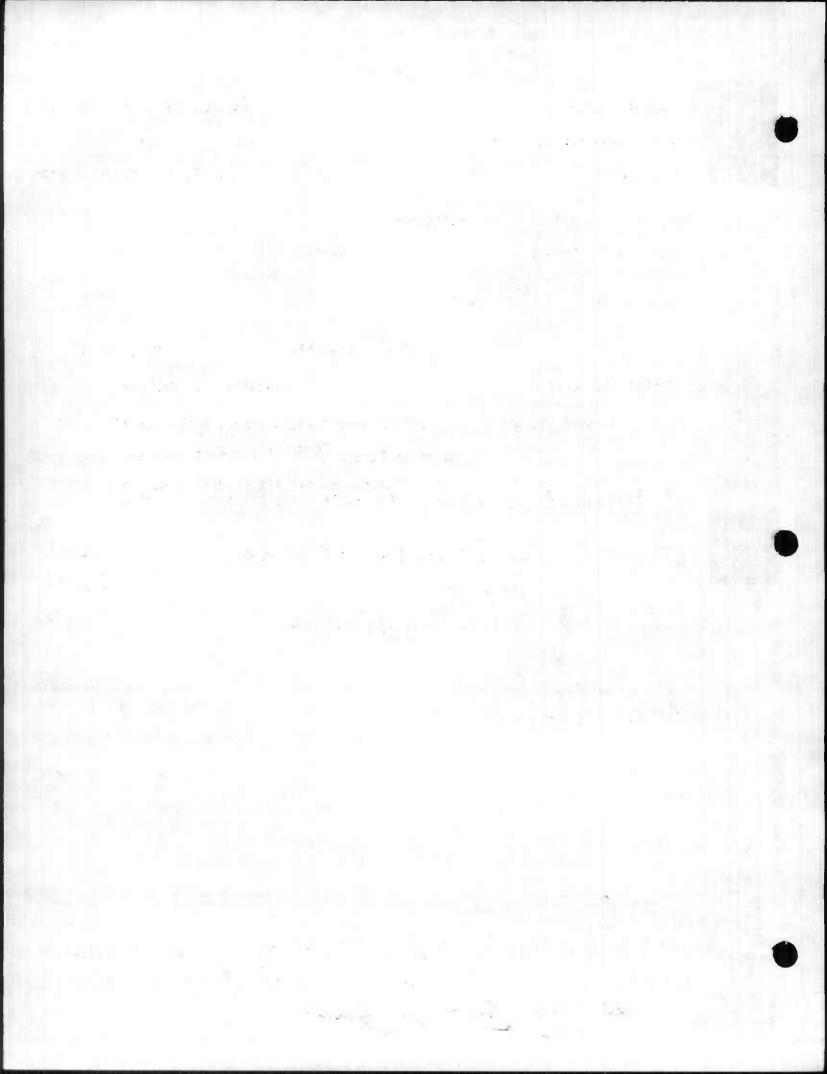
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Maryland 21218 Parkway

29d. Date signed (Month, Dey, Year)

November 24, 1999



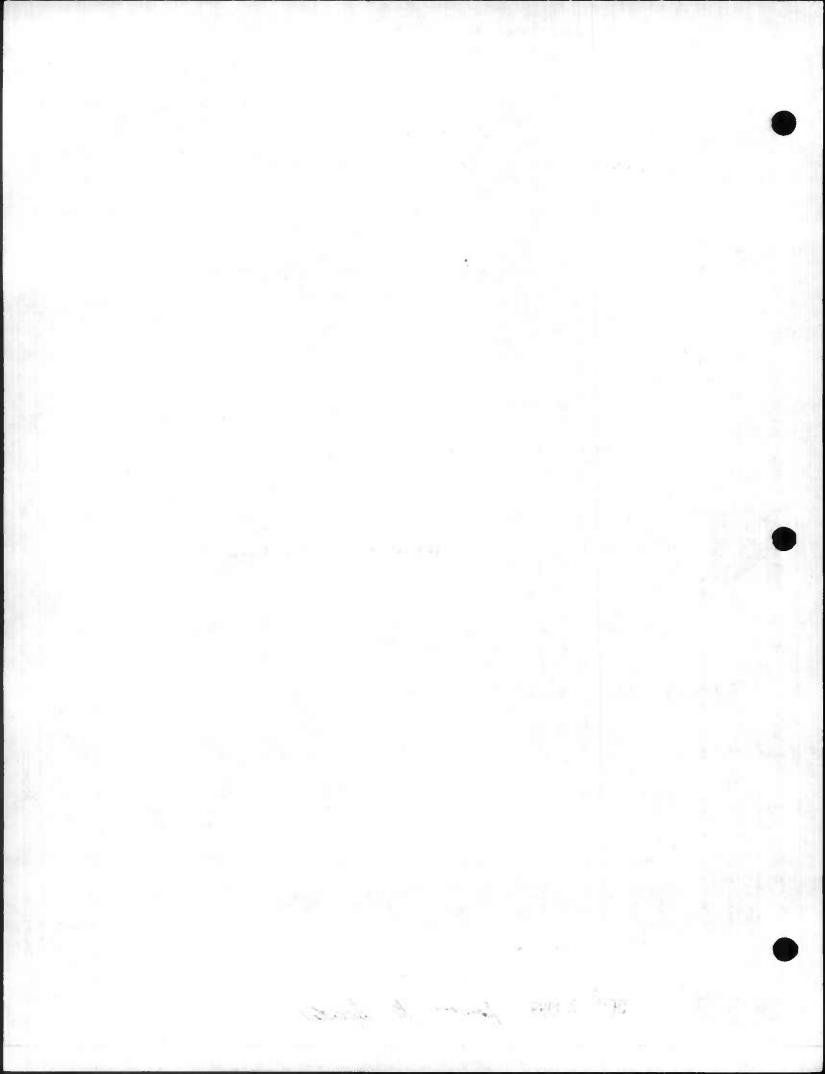
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State of Maryland / Department of Health and Mental Hygiene 9 9 37667

Certificate of Death Reg. No.

Physician /Medical Examiner	Bernard	M. Loh:							2. Date of D	eath	3.	Time of Death	
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	30 Neme and add	ress of person who	completed cause o	death (Item	23a) (Type, I	Print)	1 01		2 /	timor	1 > 10	0	

DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item #1, per phy G7789/99, Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Orrie Long Elizabeth 11 25 99 7:50p.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4009 White Ave Apt 2B Baltimore ff Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X F 213-34-6653 Usual Rasidence of Decedent 62 26 37 M.D 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4009 White Ave 2B 21206 U.S.A. Funeral Apt 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2% No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify. p 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Pharmacy Clerk Mercy Hosp. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry R. Shaw
19a. Informent's Name/Ralationship (Type, Print) Ada Hawkins 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Diana Long-Daughter 4033 Elmora Ave, Baltimore Md 20e. Mathod of Disposition 20b. Plece of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ▼ Tremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Metro Crematory Inc. 12/03/99 Baltimore Md 22. Name and Address of Fecility 21. Signeture of Funding Service Licensee March F/H West 4300 Wabash Ave, Baltimore Md 21215 Part Little the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Betw Onset end Deett Immediete Ceuse (Finel disaasa or condition resulting in daath) Respirator / week Examiner Vena cava Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Oue to (or as a consequence of) Lung Con ces Physician/Medical Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1/2 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 20No 1 ☐ Yes 1 Yes 2 No 25. Was casa rafarred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of Injury 27. Mannar of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

Box 68760. P.O. Records,

The law requires that the death certificate be exec certificate hes Attending Physician: this funeral death. filled in by

Funeral

Director

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Hygiene.

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Physician /Medical

Examiner

72 hours after

21215-0020

Baltimore, Maryland

Division of Vital To the Hospital or Attenwithin 24 hours effer deat To the Funeral Director:

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State Registrar

31. Data filed (Month, Day, Year)

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29b. Signeture and trie of certifier

30. Neme and address of person who com

29e. Certifier (Check only one)

> Waterfield 32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 520 PM Lawson Hovember 28 1999 Sarah M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultmore Hospital of Mai Galtimore If Under 1 Year | Months | Days If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 200 Months Hours Min. Director 12 V.A 214-24-4478 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limita 28a-f show 1 XYas 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 "natural", or items 23s 21215 U.S.A. 2316 Ocala Ave 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
if Yes, Give Y
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify Black P 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) llth grade Domestic Worker Private na is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Thelma Lawson McKinley Carter 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. Elaine Brandon-Niece 21215 2316 Ocala Ave, Baltimore Md 20b. Ptace of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 12/3/99 Owings Mills, Md 21. Signature of Fungeti Service Licansee 22. Name end Address of Fecility March F/H West 4300 Wabash Aye, Baltimore Md 21215 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Severe Anoxic Brain Examiner Physician/Medical Examiner Pulseless Cardine Electrical physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Dua to (or as a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by the Anemia Hypertension, Division of Vital Records. by 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 210 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After or Attanding 1 Netural 5 Pending investigation sfter death.

Director: Aft
d in by the fur 1 TYes 2 No 2 Accident 3 ☐ Suicida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletaly filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13206 M. O. November 28, 1999 Bultimore, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakil Khan of 1timore Hospital 2401 W. Beliedere Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1999 Registrar DEC 02

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Deta of Deeth 3. Tima of Death Dav **Physician** November 28, 1999
position of Death 4c. County of Death DOROTHY Τ. LOWINSKI 8:35 A, M /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Square Hospital Center
7. Age (In frs. last birthday) If Under 1 Yac Rose da/e FRANKLIN Baltimore Birthplece (Stata or Foreign Country)
 NEW YORK Social Security Number If Under 1 Yaer **Funeral** Months Days 10 M XXF Hours 071-16-0652 78 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Example: must be notified at 1 Yas 2 XNo Funeral Director BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1314 CHAPEL HILL DRIVE 21237 U.S.A. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Wes Decedant of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) 12 HOUSEWIFE DOMESTIC 7 is marked other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental UNKNOWN TIVOLA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traur ANDREW LOWINSKI/ HUSBAND 1314 CHAPEL HILL DRIVE, ROSEDALE, MARYLAND 21237 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY ROSARY CEMETERY 12/1/99 BALTIMORE, MARYLAND 21. Signature of Funarel Sarvice Licenses 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiretory arrest, shock, or heart failura. List only one cause on each line. 21231 Approximate Interval Batwean Onset and Death **Physician** /Medical Immediata Causa (Final · Arteriosclerotic Coronary artery Disease disease or condition resulting in deeth) Examiner Examiner tension Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Lest Dua to (or es a consequence of): Box 68760. by Physician/Medical Dua to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DISPOSE Cerebrovascular Records. 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to Osteopetrosis completion of ceuse of death? Ostenarthritis of hips AND KNEES 1 Yes 2 No 1 ☐ Yas 2 No of Vital or Attending Physician: 25. Wes cese reterred to medicel examiner? Be 26. Place of Death (Check only ona) Hospitel: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 20 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After Division 5 Pending investigation 1 Natural death. 1 Yas 2 No 2 Accident 24 hours after deatl 6 Could not be datermined 3 Suicida 28a. Plece of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29b. Signatura and title of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year)

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30. Name and address of purson who complated ceusa of death (Itam 23a) (Type, Print)

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DR. Will, Am.
31. Date filed (Month, Day, Year)
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November 30, 1999

Square Drive BAltimore, MD 21237

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 35 Am Annie M., MC G. 4a Facility Name (If not institution, give street and number) 99 4c. County of Death 4b. City, Town, or Location of Death BON SECOUR BALTIMORE N/A If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Days Months Hours 1 ☐ M 2 🗓 F SC 214 20 5830 02/02/1922 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1∏Yes 2□No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 617 N. AUGUSTA AVENUE 21229 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: BLACK 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER KAY PACKING CO. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) JOSEPH MCDANIELS PRISCILLA CANTY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) LEON WASHINGTON/SON 3909 CLARINTH RD BALTO., MD 21215 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other p Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ARBUTUS 12/6/99 BALTO., MD. 21 Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode or oying, such as cardiac or respiratory arrest. 21217 shock, or heart failure. List only one cause on a ach lina. Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Nypercholes erolem () 25. Was case referred to medical examinar? Hospital: 1 Yes 2 000 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Examine

Completed by Physician/Medical

Be

edicai Certification: To

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicida

(Check only one)

permit. Page Department of Important: If any Injury or page.

Physician

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Funeral

Director

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r than "natural", or hen the Medical Examiner.

Pages 1 and 2 should be filed within 72 hours after ont of Heelth and Mental thygiene.
In: If them 27 le marked other than "natural", or the III yor other traumatic event, the Med.

Director MD

Funeral

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21215-0020

Baltimore, Maryland

The law requires that the death certificate be executed burial-transit Bud physicien s the buria ed by the attending p deteched for use as signed by t certificate hes

Box 68760. P.O. Division of Vital Records. or Attending Physicien: After this funeral 24 hours after death.

Funeral Director: A filled in by

completely within 2 To the F ag the 0

Hospital

State Registrar

29b. Signature and title of certifier

5 Pending invastigation

6 Could not be datarmined

29c. License number

1 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

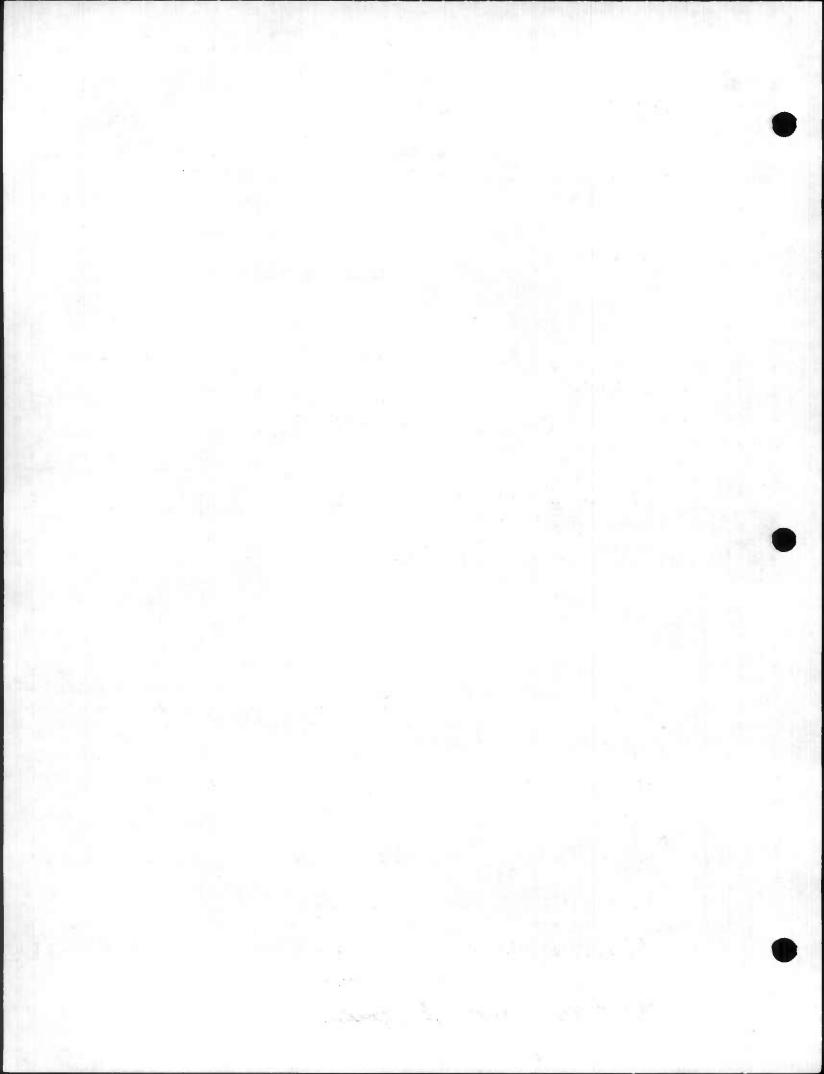
30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

700 WASH BIND BART MO KEARNEY MO

28a. Place of Injury - At home, tarm, street, tactory, office building, atc. (Specify)

Year) 1999

32. Registrar's Signature



Please Type or Print in Black Indeible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Helen Murphy 26 99 /Medical 9:45p.m. 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Baltimore 4004 Gwynn Oak Ave If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 20 F 82 Director 220-14-9924 0.3 30 M.D the Meryland 10a. Stete 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4004 Gwynn Oak U.S.A.

14. Rece - American Indien, Funaral Ave 21207 12. Wes Decedent Ever in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygione.
It: If item 27 Is marked other than 'netural', or Ne my or other traumatic event, the Medical Process. 1 Yes 2 No 1 ☐ Never Merried 2 ☐ Merried 21215-0020 1 Yes 2 No Specify: p Specify: 3€Vidowed 4 Divorced Yeer or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Fether's Neme (First, Middle, Last) Aide Balto. City Schools Baltimore, Maryland 18. Mother's Neme (First, Middle, Maiden Surname) 8 Herman Baker Anna Waters 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Wilson-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ave. Baltimore md 21207

20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from Stete Important: H any injury o 2008. Department 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 12/01/99 Glen Burnie, Md 22. Name and Address of Facility
March F/H 21. Signature of Funerel Service Licensee 4300 Wabash Ave, Baltimore Md 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Finel months metastatic cell cancer disease or condition resulting in death) Examiner Due to (or es a consequence of) Examinar sician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. physician Physician/Medical the Due to (or es a consequence of): 2 080 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Complated by 24b. Were autopsy findings aveilable prior to completion of cause of death? should 24a. Wes an autopsy performed? page 2 has 1 ☐ Yes 2 No certificata 1 ☐ Yes Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Ba 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural e Hospital or Attending 124 hours after death. • Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) within 2. To the 29b. Signetury end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 MO ecuona 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) North St Calvert 315 Baltimore MO 21202

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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37673 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month November 25 Pag **Physician** -eod doN 600 PM E /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 04 BACTIMORE BALTIMORE HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplaca (Stete or Foreign Country) 5. Social Security Number **Funeral** Months Days 100M 2□F 239-09-5160 Usual Residence of Decedent Director 10a. State 10h. Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Wedlesi Examiner must be notified at Baltimore 1 Yes 2 No Director N 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. 14. Race - American Indien, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, Whita, etc. 1 Never Merried 2 Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: 3 DWidowed 4 □ Divorced S Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit.
Department of Health and Mentel Hyglene importants if item 27 ie marked other the eny injury or other traumatic event, that pages. 10+H GRADE Mechanic NIA 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) 8 Chapman Maelie DOISED 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3411 W Hd 21216 Dalto. NIECE & becca 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State VATIONAL 112 4 Donation 5 Other (Specify) ALUERTON ana 22. Name and Address of Facility
PARCH FUNGRAL
4300 Wabash 21. Signature of Funeral Service Licensee Home West March Md 4300 23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear (gilure. List only one cause on each line. 2 Approximete Intervel Batween Onset end Deeth **Physician** /Medical PNEUMONIA Immediate Cause (Fine) HOURS ASPIRATION disease or condition resulting in death) Examiner OBSTONICTIVE PUZMONARY DISEASE YEARS Examiner CHASINIC physicien end the burlei-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical Due to (or as a consequence of). 23b. Did tobacco use contribute to the cause of geath? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1□ Yes 2 No 1 Yes 2 No Division of Vital depital or Attanding Physician: Ti 4 hours after deeth. *unerel Director: After this certificat isly filled in by the funeral director, pu 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manger of Death 28a. Data ol Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and menner stated. within 2 To the mo 29d. Data signed (Month, Day, Year) 29b. Sigr 29c. License number D0053495 NOVEMBER 25, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE KRAWER MD RYAN M. SINAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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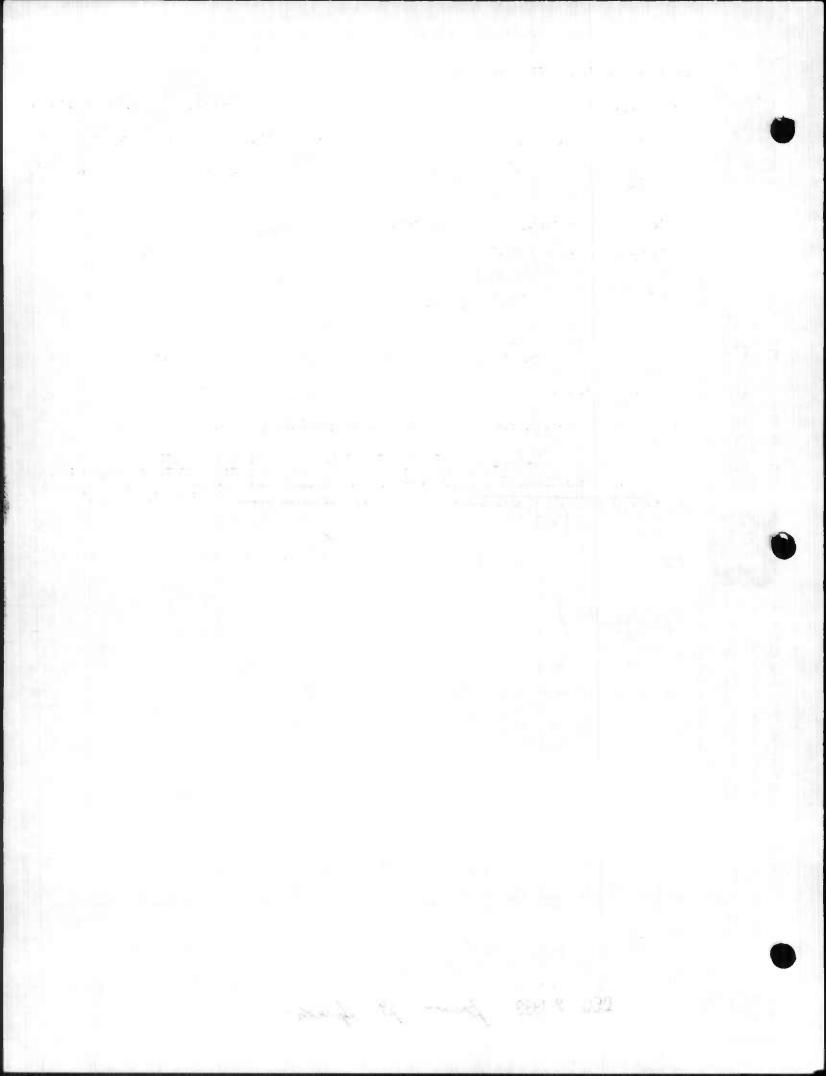
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	Physici		1. Decedent's Nama (First, Middla, Last) Laura AShley	Putton		2. Data of De Month NOV .	28, 199	Year O	3. Time of Death 1307 PM				
	/Medic Examin		4e Facility Name (If not institution, give str UNIVERSITY HOSPIT	reet and number) TAL S.T.U	4b. City, Town, or Lo	or Location of Death 4c. County of Death							
	Funeral Director		5. Social Security Number 6. Sex 101	7. Age (in yrs.		8. Data of Bir Nonth, Da	N/A	9. Birthpla	ca (Stata or Foreign				
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	Sa-fa	octo	MD N/A	130	altimo						1 Yes 2 □ No		
	h with th	al Dir	510 South Gilmo	r St.		21223	3		10g. Citizen of	Stot	n CS		
050	72 hours after death with the Manyland netural; or items 23s or 28s-f ahow deal Examiner must be notified at	by Funeral Director		2. Wes Decedent Evar in L Armed Forces? 1 Yas 2 No If Yas, Giva Yaar or Datas:			dispanic Origin? (Spi an, Mexican, Puarto Specify:	ecify Yas or No Rican, atc.)	14. Rac Blac Specify	Indian,			
21215-0020	n 72 hours "næturel",	leted	15. Decedent's Educa (Specify only highest grade of		16a. Decedent's Usual Occupation (Giva kind of work done during m			ing	16b. Kind of B	d of Business/Industry			
	filed within 72 h Hygiene. ther than "netu ent, tra Medical	Completed	Elementary/Secondary (0-12)	Collega (1-4or 5+)	Stud				Elemer	Hary	School		
Maryland	should be filed and Mental Hygi le merked other eumatic event, I	To Be	17. Father's Nema (First, Middla, Last) Walton Newtor	Sr		9	Thereso	Bol	yard	9			
	127 E		Theresa New Hon /	mother	19b. Mailin	g Address (Street	S All P	A LiM	City or Town,	State, Zip C	ode))2		
Baltimore,	of H		20a. Mathed of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Rar	20b.	Place of Dispos cematary, cren	sition (Nama of natory or other pla	ce) (O)	Date	20c. Location -	^ ^	1 1		
Itim			4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licentum	XX /6	eadouri	dae (V lem	orial Yark L	2/3/1999			ryland		
Ba	Departi Departi Importa any Inje		1 Slan D	moran	13	1285 John	e Socion Rd	brose + Baltin	uneral	2122°			
			23a. Part1. Enter the disaasa, or complice shock, or haart failure. List only ona	alions that caused the dae causa on each line.	th. Do not ente	ar tha mode of dyi	711119			1	Approximeta ntarval Between		
	Physician /Medical Examiner		Immediate Causa (Final disease or condition rasulting in death) e	Smolt	e 11	nhalat	ion		9		Onset and Death		
		ner		Dua to (or as a conseq	uence of):							
,0	icete be asscuted physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
Box 68760,		n/Medical	Causa (Diseasa or Injury that initiated events rasulting in death) Last			10							
	the atte	Physician/M	Part II. Other significant conditions contri	buting to death but not ras	sulting in the un	iderlying ceusa git	ven in Part I.	23b. Did	tobacco use co	ntribute to t	he cause of death?		
P.0	es that the de							10	Yes 20 No	3 Probe	bly 4 Unknown		
Records,	aw requires is been sign 2 should be	Completed by				24e. Wes	en eutopsy med?	avail	a autopsy tindings lable prior to pletion of cause path?				
	The ate h	Com		H				1風	res 2□ No	12	Yas 2□ No		
Vital	Physicien: The this certificate ral director, pag	o Be	25. Wes casa rafarred to medical examinar? Nation No Hos	spital:	3500	Ott	26. Placa of Death			(0/4.)			
J of	After this funeral d	-	27. Mannar of Death	1 ☐ Inpatient ★ 28a. Data of Injury (Month, Day Year)	ER/Outpatien 28b. Tima of Injury	28c. Inju	4LI Nursing Ho		now injury occur				
Sior	Attending or death. octor: After by the fund	catlo	1 Natural 5 Panding 2 Accident invastigation	11-28-99	1300	M 10	Yas 2MNo	House					
Division	or Attendate sher deat	Certification:	4 Homicida datermined	building, etc. (Specify)							Route Number, Gilmore St.		
	Hospi 24 hou Funer etely fill	edical C	29a. Cartifiar 1 Certifying Physic (Check only one)	Reside iten: To the best of my knor: On the basis of examine and mannar steted.	owiedge, deeth	occurred at the tile estigation, in my o	ma, data and place,	and dua to tha	cause(s) and medate end plece,	ennar as sta	ted.		
	To the To the compl	×	29b. Signeture end title of certifiar	- 1	4	29c. Licens	se number		29d. Data signe	d (Month, Di	ay, Year)		
			stysh 1	Vlac	15,1	40	C.M.E		NOV.	29,	1999		
	0		30. Nama and address of person who com Strohen 5, Ra				t, Baltimo	ore, Mai	yland 2	1201			
	Stat Registra		31. Data filed (Month, Day, Year) 2 19	32 Benjetrar'e Sign	atura	1 spa	K						

And the second of the second o

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AM	END#20a - 22 PER F.H 1. Decedent'a Name (First, Mi		99 J.A. <i>Ce</i>	ertificate of	Death	2. Date of Dea	leg. No.	3	. Tima of Death		
cian	Christine Ne					Novemb	er 23.	Year	14:35 PM		
lical iner	4a Facility Name (If not institu		r)		4b. City, Town, or L	1	4c. County	of Death			
içi	118 Monroe S	treet #210			Rockville	2	Mont	gomery			
	5. Social Sacurity Number	6. Sex 7. /	Age (In yrs. last birthda)	/) If Undar 1 Yaar Months Days		8. Date of Birth (Month, Day	(Vear)	9. Birthplace	(State or Foreign		
	350-28-0587	1□M 2X0F	78 Yrs.	Months Days	Tiouis Wiit.	Apr 24,	1921		owa		
	Usual Residence of Decedent 10a, State 10b, Cou	ntv	10c. City, Town or I	ocation				104	Inside City Limits		
5									1 □ Yas 2√□ No		
ect	MD Mor	itgomery	Rockvi	10f. Zip Code			IOg. Citizen of V		24		
Funeral Director	118 Monroe	Street #210		208	350		USA				
Jero	11. Marital Status	12. Was Deceder	nt Ever in U,S. 13	. Was Decedent of	Hispanic Origin? (Sp	pecify Yes or No-		e - American I	Indian,		
2	1 Navar Married 2 Navar Marri	If Yes, Give		1 ☐ Yes 2 No	Specify:	Hican, etc.)		ck, Whita, etc. White	2		
Completed	15. Deced	lent's Education hest grade completed)	pation	kina	16b. Kind of Bu	ind of Business/Industry					
npie	Elementery/Secondary (0-1)		r 5+)	DO NOT use retire	during most of work ed)						
	12	4	Nu	ırse	Lange	4577	Healt				
Be	17. Fathar's Nama (First, Midd				18. Mother's Nam			16)			
0	Allen G. Al		405 34-1	Non-Addison (Ohno-		Renning		Chair Zin Co	da 1		
	19a. Informant's Name/Relation				and Number or Ru				00)		
	Esther Kessli 20a. Method of Disposition		20b. Place of Disp	osition (Name of	oad Jenki	nstown,	PA 190 20c. Location -		Stata		
	1 Burial 2 Crematic	n 3 □Removal from Stat (Specify) In Stat	0	ematory or other play MATORY INC.		12/9 ,/99	BALTIMORE	MD			
	21. Signature of Juneral Serv		EMATION SO	MATION SOCIETY OF MARYLAND INC.							
	KO.	nald S. Wade	DITTECTOL	22. Name and Addr	lateothy bot	rd 655 1	W. Balt.	imore S	Street TO. MD 2122		
-	Part1. Enter the disease	or complications that caus ist only one ceuse on each		Baltimor					proximate erval Between		
clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	6		(or as a consequence of):							
in/Medical	that initiated events resulting in death) Last	d	Due to (or as a conse	equance of):							
Physician/M	Part II. Other eignificant cond	itione contributing to death	but not resulting in the	underlying cause g	iven In Part I.	23b. Did t	b. Did tobacco use contributs to the cause of death?				
by Phy						101	700 2 No	3 Probab	ly 4 Unknown		
Completed b						24a. Was a	an autopsy med?	availal	autopsy findings ble prior to lation of causa th?		
ошо						1 D Y	es 20 No	1 🗆 Y	L		
Bec	25. Was case refarred to med examinar?	cal			26. Place of Dee	th (Check only o	ne)				
To.	1 Yes 2 No	Hospital: 1 ☐ Inpa	tiant 2 ER/Outpati	ent 3 DOA	ther: 4 Nursing H	oma 5 Resid	lenca 6 □Oth	er (Specify)			
Certification:	E LI Accident	stigation	glury Day Year) 28b. Time Injury	Wo	aryat ork?]Yas 2□No	28d. Describe how injury occurred					
Cerum		Id not be mined 28a. Place of building,	njury - At home, farm, s etc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tow		ber or Rural R	oute Numbar,		
edical		ying Phyelcian: To the bes at Examiner: On the basis and manner	of examination and/or l								
×	29b. Signature and title of cert	fier () —	1 hma	29c. Licen	ise number		29d. Date signe	d (Month, Day	v, Year)		
	Patricia	L. loms	120,1100	D3	19 16'	/	Vovem	ben a	13, 1999		
	Name and address of pers	Tomsko, N	death (Item 23a) (Type	ock ville	Pike, P	MB 348	Rock	ville,	n3, 1999 MD 2085		
	31. Data filed (Month Clay Ve	20/2	stear's Signeture		7						

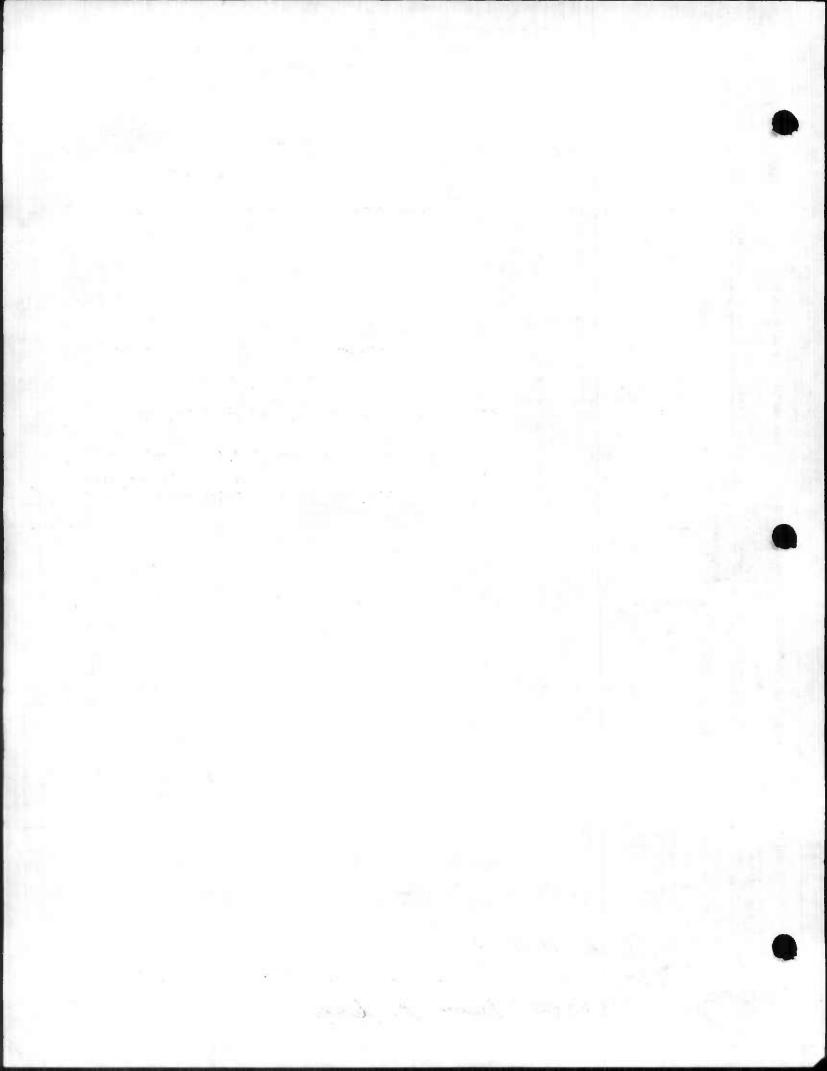
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	AN ROSS	EMS: #23 PART I	9 6/ 1 111 111	nd / Departme	nt of Health and	Mental Hy	eth		676 me of Death			
	Physician /Medical Examiner	Alan Stephen Ros 4a Facility Name (If not institution, give GREATER BALTIMORE	street and number) E MEDICAL CENT		Towson	_	BALT	of Deeth	011 AM			
_	Funeral Director	UZ/-54-U556 Usual Residence of Decedent	_XM 2□ F	37 Yrs. Months		. (Month, Da	h, Year) 3,1962		MA			
5-0020 72 hours after death with the Meryland	or 28e-f ahow be notified at Director	MD Baltimor		ity. Town or Location)Wings Mill			toe Civines of M	10	ide City Limits Yes 2 No			
- S	23a or rai Dir	4717 Deer Park Ro	C 000	101. 2	ip Code 21117		10g. Citizen of W					
020	al, or hams 234 Examinar must by Funeral	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes:		edent of Hispanic Origin? (: ecity Cuban, Mexican, Pue 2 No Specify:	Specify Yes or No nto Rican, etc.)	USA 14. Rece Blec Specify.	en,				
within 72 ho	yglene. ner than "natural", t, me terd a Est. Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	uel Occupation rork done during most of we use retired) ter	orking		White bb. Kind of Business/Industry					
ind 2	d out	17. Father'e Neme (First, Middle, Last) Joseph W. Ross	ame (First, Middle, A. 01 son	Construction Idle, Maiden Sumeme) On								
	n 27 la ma her trauma	19a. Informent's Name/Reletionship (7) Denise C. Ross	Wife	4717 Deer	Park Rd., 0	wings Mi	lls, MD	21117				
Baltimore,	eriment of F orlant: If he Injury or of	20a. Method of Disposition 1 CX Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetory or other place) Crestlawn Memorial Gard. 12/2/99 Marriottsville, 21. Separation of Funeral Service Licensee										
Ba	Department important any injure page.	23a Part1. Enter the disease, or companyols, or heart failure. List only of	I lun	Eline	Funeral Hom	e Reiste	Reister	MD 2113				
1	nysician Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	MITRAL VA	LVE PROLA	PSE AND FO ATHEROSCL	CAL MOD			el Between and Deeth			
760,	ysician and na burlat-transit Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	bDue to (or as a consequence of):							
. Box 6876	igned by the attending physicis be detached for use as the bur by Physician/Medical	that initiated events resulting in death) Last	Due to (d	or as e consequence of):							
O. O.	the atta	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the underlying	cause given in Pert I.	23b. Did tobacco use contribute to the cause of death?						
is, P.O.	igned by be detect						Yea 2□No	3 Probably	4 Unknown			
of Vital Records, Physician: The law requires t	2 2 5						an eutopsy med?	of desth?	prior to in of cause			
S E	cartificata irector, pag DBe Co	25. Was case referred to medical			OC Plans of D	eath (Check only o	res 2□No	1 D Yes	2 No			
on of Vita	울을 다	examiner? 177 ves 2 No 27. Manner of Death 1 17 Natural 5 Pending	Hospitet: 1 Inpatient 2 S 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Other	Home 5□ Resid						
2 5	ins after death. al Diractor: After tiled in by the funeral Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Place of Injury - At h building, etc. (Speci		28f. Location (S City or Tox	Street and Number, Stete)	er or Rural Route	Number,				
To the Hospital	within 24 hours and To the Funeral Completely filled	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of my kniner: On the basis of examinating and manner steted.	owledge, death occurre ation and/or investigation	d at the time, date end placen, in my opinion, death occ	e, and due to the curred et the time,	cause(s) end ma date end plece, a	nner as stated. and due to the ce	use(s)			
Toth	To the comp	29b. Signeture and little of certifier	11/1-	2	9c. License number O.C.M.E	14-	29d. Date signed	(Month, Dey, Yo				
		30. Name and address of person who co		m 23a) (Type, Print) 11 Penn St	reet, Baltim	ore, Mary						
	State Registrar	31. Date filed (Month, Day, Year) DEC 0 2 19	1 /	ature	books							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Day **Physician** 9:30AM November 28, 1999
cation of Death 4c. County of Death Walter Glenn Resh /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Examiner 6 Ivy Bridge Ct. Reisterstown
If Under 1 Year If Under 24 Hrs. 8. Date
Months Days Hours Min. 8. (Mor Baltimore 6. Sax X(X) M 2□ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Yrs. 74 Director 213-22-4060 June 2, 1925 MD Usual Residence of Decedent the Merylend 10c. City, Town or Location 10a. State 10b. County 10d. insida City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylen Department of Health end Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner round be notified as 1 ☐ Yas 2 No MD Baltimore Director Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Ivy Bridge Ct. 21136 USA Funeral 12, Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ▼No If Yes, Give Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, Whita, atc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Contractor Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Orvis Resh Nora Belle Bittinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annalee F. Resh Wife 6 Ivy Bridge Ct., Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 12/1/99 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136 Usa art. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, hock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Smoking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 physician Physician/Medical the Due to (or as a consequence of): 8 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the 1 Yes 2 No 3 Probably 4 Unknown Cor pulmonale Signed 5 be det þ 24b. Were autopsy findings available prior to complation of causa of death? Completed 24e. Wes an eutopsy pege 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 € No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidenca 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 2 Naturel 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner stated. 29a, Certifier edicai (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifie, 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

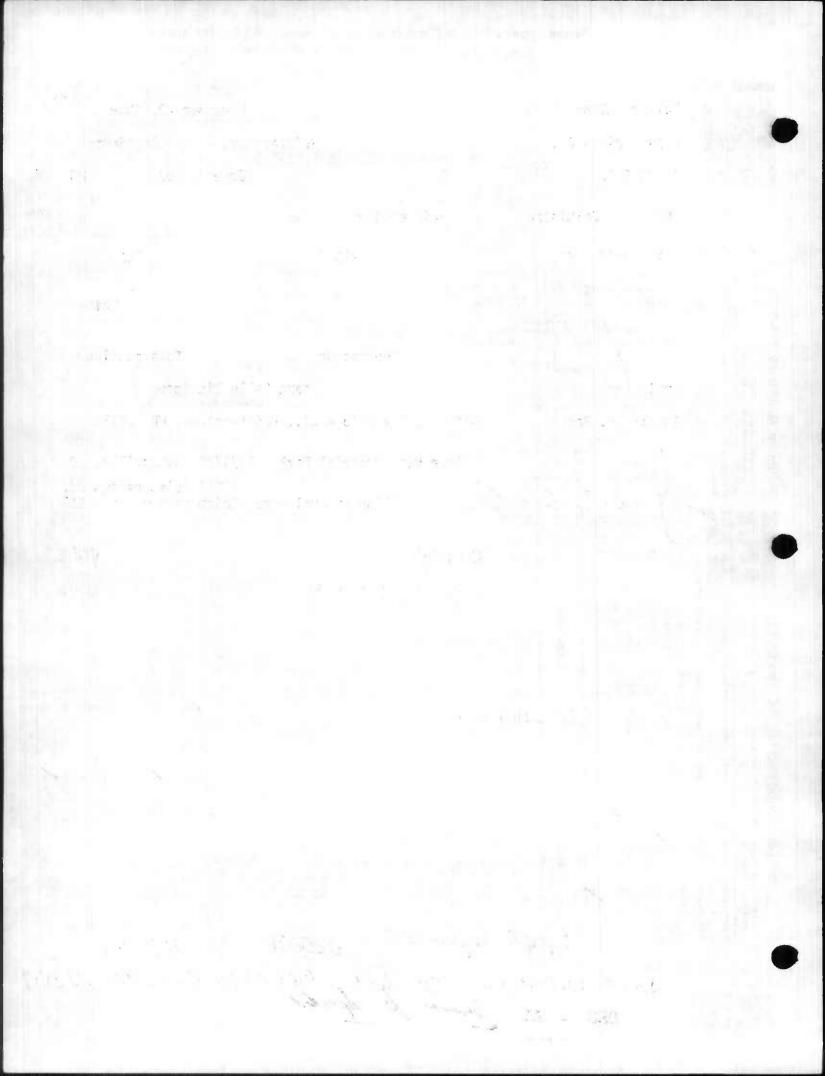
JAY H LIPPMAN, MO 10085 Red Run Blvd # 406 Owings Mills MO 21117

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM: 1 PER MD G778 12-2-99 WR. 1. Decedent's Neme (First, Middle, Last) MABLE EARNESTINE REMBERT 2. Dete of Deeth 3 Time of Deeth Dey Month **Physician** 11:30 AM Stine November 24 1999 /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital
5. Social Security Number 6. Sax Baltimore
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplaca (State or Foreign Country) **Funeral** Months Min 1 M XOXF Deys Hours Director 243-46-1037 67 N.C. 02 14 32 Usual Residence of Decedent the Marylend 10e. State 10c. City, Town or Location 10b. County 7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, tra Medical Examiner must be not tred at 10d. Inside City Limits Director 1 Yas 2 No MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 601 Woodington Road 21229 U.S.A. deeth 12. Wes Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian. permit. Peges 1 and 2 should be filled within 72 hours effer c Department of Health and Mental Hygiene. Introprent: If flem 27 is marked other than "naturel", or item any injury or other treumetic event, the Medical and once. Black, White, etc. Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2N No Specify: P 3 ₩ Widowed 4 Divorced Yaer or Dates: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade

17. Fether's Neme (First, Middle, Last) Cook Catholic Charities 18. Mother's Name (First, Middle, Maiden Sumeme) Be George Smith Annie Smith 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Gail Cook-Daughter 1000 Craftswood Rd., Baltimore Md 21228 20b. Plece of Disposition (Neme of cematary, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Buriai 2 Cremetion 3 Removel from State Crestlawn Mem. Gardens Marriotsville, Md 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility March F/H West 23. Par L. Enter the disease, or complications that cau led the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, she is, or heart feiture. List only one cause on each line. 4300 Wabash Ave, Baltimore Md 21215 Approximete intervel Between Onset end Deeth **Physician** immediate Ceuse (Final disease Condition resulting in death) /Medical metastatic 3yrs. colon concer Examiner Due to (or es e consequence of) Examiner physician end the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Earnestine Due to (or as a consequenca of): 38 9SH þ 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | Yes 2 PNo 3 | Probably 4 | Unknown þ 24b. Were eutopsy lindings eveilable prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed After this certificate has funeral director, page 2 2 No 1 ☐ Yes 2 ☐ No NAME KEM DERT, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitai: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident Director: 6 ☐ Could not ba 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide Pieca of Injury - At homa, farm, straat, lactory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral E 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only onel 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 140850 November 24, 1999 MA 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 900 CATON AVE BALTIMME MD 21229 OT TAV, AND MD JONNE

Any

DHMH 16 Rev 6/95

State Registrar

- 4 2000

32. Pagistrer's Signeture

99-7141-0 STEPHANIE SAWYERS	00!	5	Plea	se Type or State			d / Dep		t of I	lealth a	and N	II Coples Idental H		ne C	lble.	37679
Physician /Medica Examine	STEPHANIE LYNNE SAWYER STEPHANIE LYNNE SAWYER 4a Facility Name (If not institution, give street and number) PROVIDENCE ROAD & EAST BOUND 695 Month NOVEMBER 29, 1999 4c. County of Death BALTIMORE															
Funeral Director		5. Social Security Number 215-86-3284 Contact Security Number 32 Contact Security Number 6. Sex 1 M 2 M F 32 Usual Residence of Decedent			(In yrs. I	(last birthday) If Under 1 Yes. Months Di			er If Under 24 Hrs. ys Hours Min.		8. Date of Birth (Month, Day, Year) JAN. 1, 1967		9. Birthplace (State or Foreig Country) MARYLAND			
deeth with the Maryland me 23e or 28e-f show rmast be notified at		MARYLAND HARFORD BEL					AIR					10d. Inside				
23a or 2	Funeral Director	10e. Street and Number 659 RED OAK DRIVE						10f. Zip Code 10g. Citizen of Whe U.S.A.							untry?	
020 urs after alf, or its	2	11. Meritel Status 1 Never Married 2 Merried 3 Widowed 4 Noticed 12. Wes Decedent Ever in Armed Forces? 1 Notices? 1 Notices? 1 Yes, Give Year or Detes:											ice - American Indian, ack, While, etc. WHITE			
21215-0020 d within 72 hours after glene. If then "netural", or the the then "netural", or the the then then	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 2 YEARS					(Give kind of work done during most of working life. DO NOT use retired)							EHICLE ADMIN.		
yiand ould be file Mental Hy arked othe	99 01	17. Father's Name (First, Middle, Last) RONALD CARL WARNER						18. Mother's Name (First, Middle, Maiden Sumeme) ROSMOND ROBB								
e, Mar 1 and 2 sh Health and Pm 27 le m ther treum		19a. Informant's Na ROSMOND I		thip <i>(Type, Print)</i> NS (MOTHE	R)		19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5501 CROWS NEST DRIVE, SYKESVILLE, MD 21784								. = 0.1	
Baltimore, semil. Peges 1 a Separtment of Hea mportant: if Hem. Mich. In July or other ance.		1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State					Place of Disposition (Name of cemetery, cremetory or other place) EEN MOUNT CREMATORY Date 20c. Location - City or Town, State 12/1/99 BALTIMORE, MARYLANI									
Baltimo pemit. Peges Department of Important: If I eny injury or		21. Signeture of Fu		22. Name and Address of Fecility SCHIMUNEK FUNERAL HOME OF BEL AIR, INC. 610 W. MACPHAIL ROAD, BEL AIR, MD 21014												
Physician /Medical Examiner		23a. Part1. Enter the shock, or heel immediate Cause (disease or condition resulting in death)	t feilure. List Finet	complications that only one cause on	eech line	e.	Do not er	In	fu.	ng, such as	cardiac	or respiratory	errest,			Approximate Interval Between Onset and Death

To the Mospital or Attending Physicien: The law requires that the death certificate be execute within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely flied in by the funeral director, page 2 should be detected for use as the buriel-tran completely flied in by the funeral director, page 2 should be detected for use as the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Medical Certification: To Be Completed by Physician/Medical Exan

Due to (or as a consequence of) Due to (or es a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 4 Unknown

explother (Specify) SCENE

1 Yes 2 No 3 Probably

24a. Wes an eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Yas 2 No

25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence

1 Yes 2 No 3 DOA 2 ER/Outpatient 28b. Time of Injury 27. Manner of Death 1 Netural
2 Accident 5 Pending investigation

28c. Injury at Work? 1 Tes

29e. Certifier

29b. Signature end titte of certifie

3 Suicide 4 🗌 Homicide 6 Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

O.C.M.E.

29c. License number

NOVEMBER 30,1999

ath Item 23a) (Type, Print) 30. Name and address of person

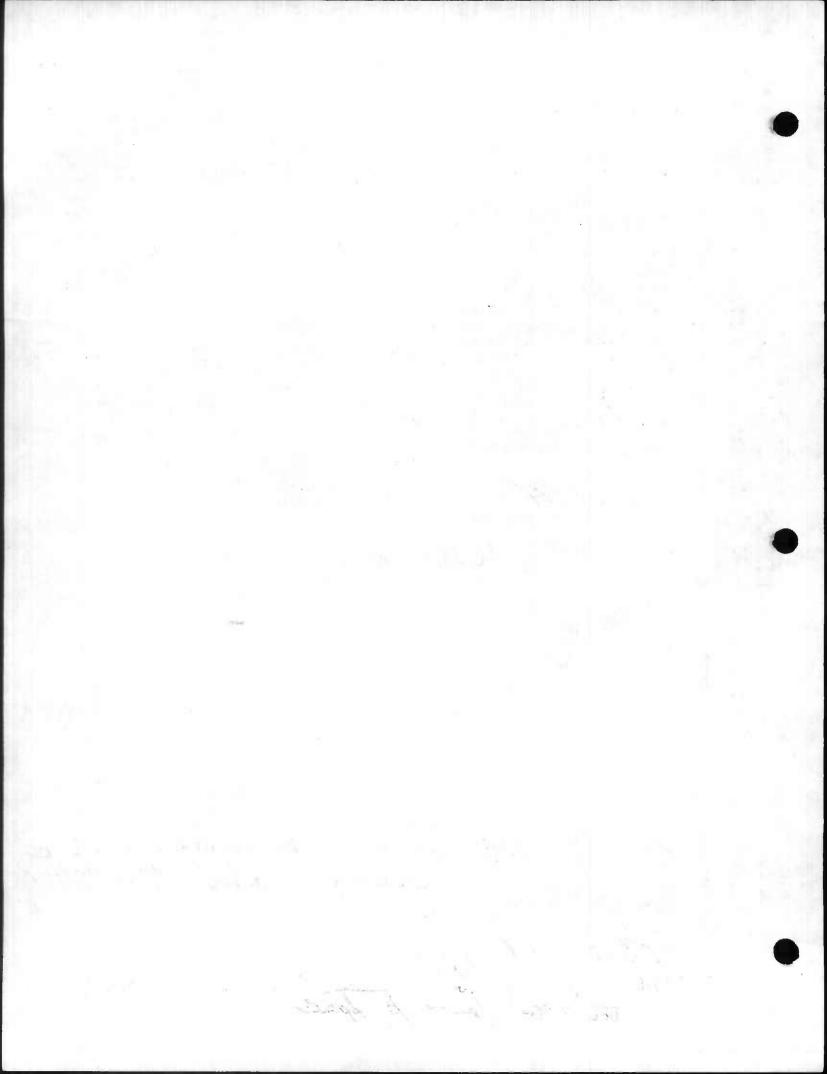
1999

THEO NO RE MI 31. Dete filed (Month, Day, Year) DEC 2 1 Penn Street, Baltimore, Maryland 21201 32. Registar's Signeture

State Registrar

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Name (First, Middle, Last) 2. Data of Daath Month 23, 1999 November Smithwick Betty 5:40 PM 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death 1931 Winder Road Baltimore County Woodlawn If Undar 24 Hrs. 8 Hours Min. If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days 1□M XXF Yrs. 220-48-9397 60 Dec. 9. 1938 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No Maryland Baltimore Woodlawn 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1931 Winder Road 21207 USA 11 Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 🔯 No If Yas, Giva Yaar or Datas: 1 X Navar Marriad 2 Marriad 1 ☐ Yas 2 ♥ No Spacify: Spacify: White 3 Widowed 4 Divorced 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Assembly Work Unknown Athelas Institute 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Will Roscoe Smithwick Marian Belle 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) David Wamsley (Guardian) 9180 Rumsy Road, Columbia, Maryland 21045 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Ramoval from State Meadowridge Memorial Park 11/29/99 Elkridge, Maryland 4 Donation 5 Other (Spacify) 21. Signature o Funaral Sarvica Licansaa 22. Nama and Addrass of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore Maryland 23a. Part1. Eyer the disease, or complications that caused the death. Do not shock, of heart failure. List only one cause on each line. Onsat and Daath immediata Causa (Final Accident 2 days disaasa or condition resulting in death) Dua to (or as e consaquance of): Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Ceuse (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequanca of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use centribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performad? 1 ☐ Yas 2 ₺ No 1 ☐ Yas 2 ☐ No 25. Was casa raterrag to medical axaminar? 26. Placa of Daath (Check only ona) 2 No Othar: 4 Nursing Homa 1 Yas 1 Inpatiant 2 ER/Outpatient 3 DOA 5 Rasidance 6 Other (Specify) 27. Manner of Daeth 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending invastigation

Examiner Attending Physician: The law requiras that the death certificate be axecuted and P.O. Box 68760, attending physician for use as the buna s been signed by the should be detach Records, certificate Division of Vital this After death. spital or Attenditions after death.

Physician/Medical þ Completed Be 2 Certification:

Physician

/Medical

Examiner

10a State

Funeral

Director

show

items 23a or 28a-f shov instribute notified at

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'natural',

al Hygiene.

. Pages 1 and 2 should be filt ment of Health and Mental Hy tant: If item 27 is marked oth jury or other traumatic event

Department of Important: If any injury or

Physician /Medical

Examiner

other traumatic event, the Medical Examiner

filed within 72 hours after

21215-0020

Baltimore, Maryland

Director

by Funeral

Completed

Be

State

Medical

Registrar

2 Accident 3 Suicida

4 Homicide

29a. Cartifiar

29c. Licansa number

1 Certifying Physician: To the bast of my knowladga, daath occurred at tha tima, data and place, and due to the ceusa(s) and mannar as statad.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and mennar statad.

1 ☐ Yes 2 ☐ No

29d. Data signed (Month, Day, Year)

30. Nema and address of person who completed causa of daath (Itany 27a) (Type, Print) ROBERT AMMLUNA MO

1120 N.

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata)

31. Data filed (Month, Day, Yaar)

29b. Signatura and titla of certifiar

32. Registrar's Signatura

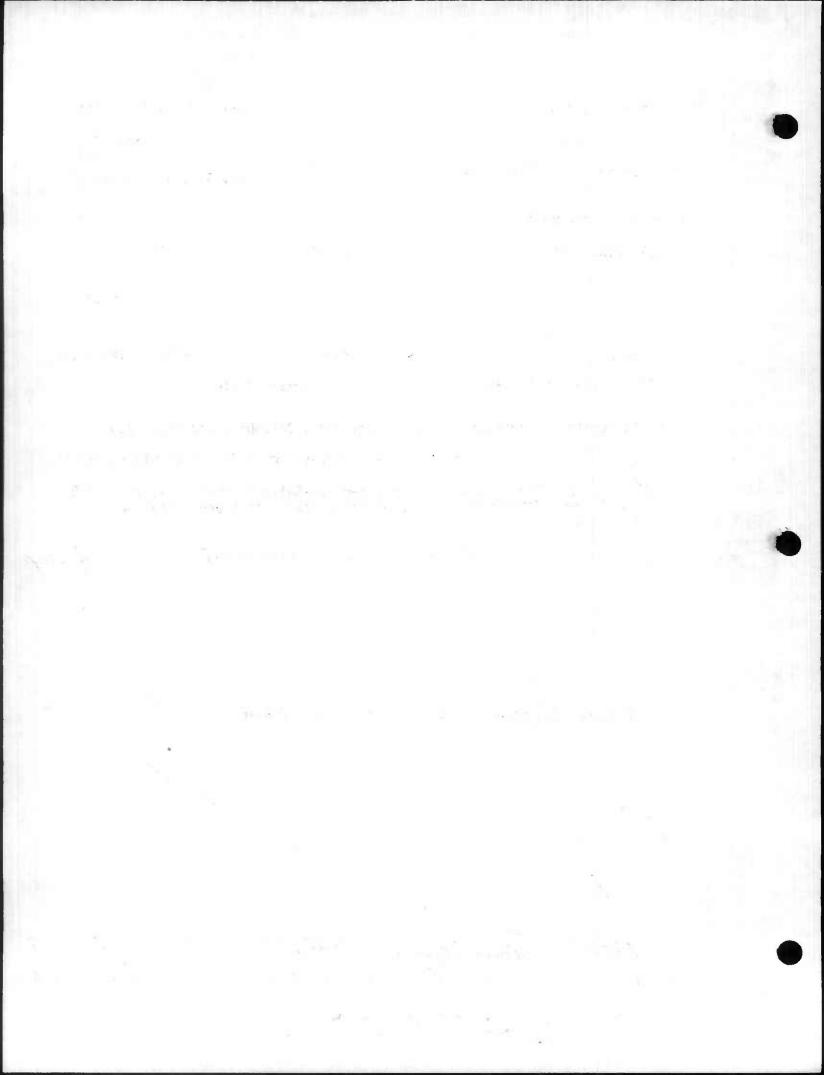
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

DHMH 16 Rev 6/95

To the Hospital o within 24 hours af To the Funeral Di completaly filled is

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6 Could not ba

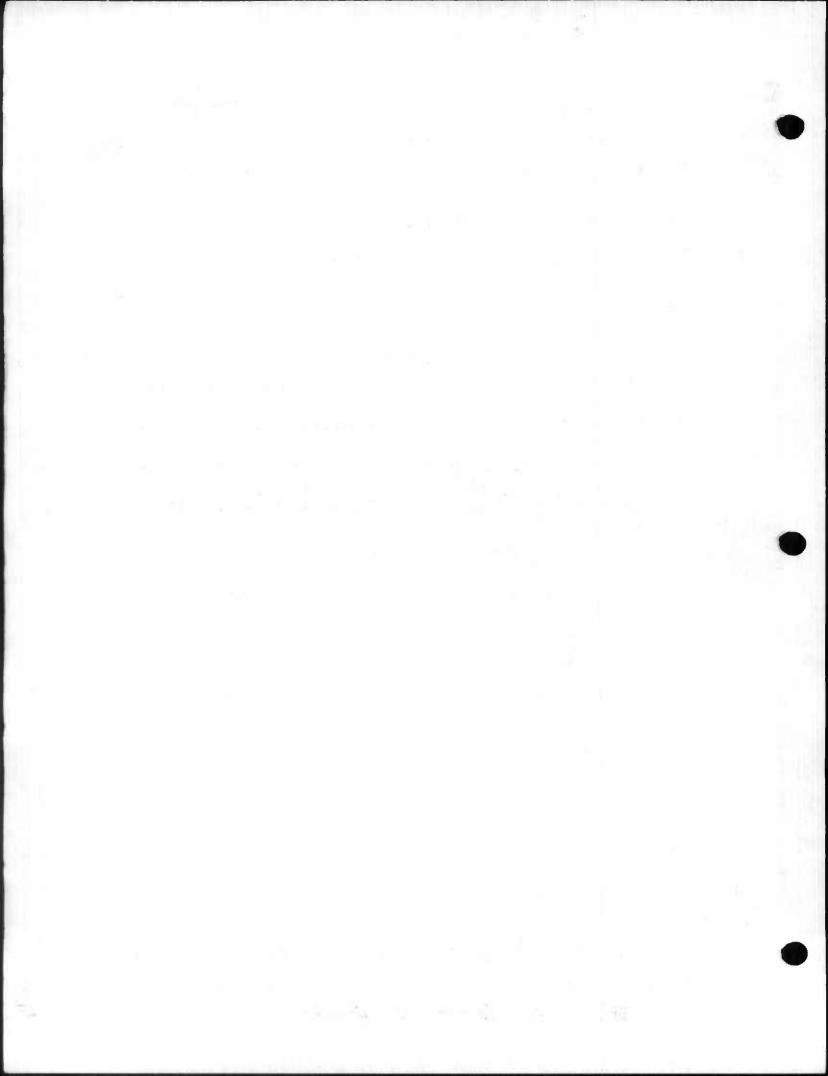


State of Maryland / Department of Health and Mental Hygiene

37681

							C	ertificate o	f Death		Reg. No.		01001	
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y	Examir	er	4a. Facility Name (If i				å		4b. City, Town, or		32.510.0			
L			Dulaney						Baltimo				imore	
	Funeral Director		5. Social Security Nu 216-10-8	344	Sex 7. 1□M 2□F	Aga (In yrs. las	Yrs.	Months Dey	s Hours Min.	8. Date of Birth (Month, De) 05-04	, Year) - 0 7	9. Birthpi Count MD	lece (Stete or Foraign try))
	ano		Usual Residence of I	Decedant 10b. County		10c. City, 7	own or	Location				16	0d. Inside City Limits	
	Manylan f show	ō	MD	N/A		Balt	imo	ro					1 √Yes 2 No	
	r 28a-f st	rec	10e. Street end Numi			Daic	Into	10f. Zip Code			10g. Citizen of V	Whet Coun	try?	-
	th with	ai D	7200 Bri	dgewoo	d Drive			212	24	1	USA			
5-0020	72 hours after death with the Marylano netural', or items 23e or 28a-f show dissa Examinet must be notified at	by Funeral Director	11. Maritel Stetus 1 ☐ Never Merria 3 🏿 Widowed 4		12. Was Decede Armed Force 1 Yes 2 If Yes, Give 4 Year or Date	os? No	13	3. Was Decedent of If Yes, specify Cu 1 Yes 27 No	Hispenic Origin? (Stan, Mexicen, Puerto Specify:		14. Rec Blac	e - Amarko ck, White, c Whit	etc.	
5-0	72 ho	To Be Completed	(Specifi	5. Decedent's	Educetion rede completed)	1	6e. Dec	cedent's Usuel Occ	upation e during most of wor	deina	16b. Kind of Bu	usiness/Ind	lustry	
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re,	F He tem		20e. Method of Dispo	sition		20b. Plec	e of Dis	position (Neme of rematory or other p		Dete	20c. Location -			-
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я	Physiclan	Н	SHOOK, OFFIBER	List on	y one couse on eyo	iiiie.	9	4	00		. 0	1	Interval Between Onset and Deeth	
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n of	ng Pt fter th		27. Manner of Deeth Naturel	5 Pending	28a. Dete of II (Month, I	njury 28 Da <i>y Year)</i>	b. Time Injury		ury et ork?	28d. Describe h	ow injury occur	red		Ξ
Division	Attending or death. ector: After by the fune	Certification:	2 Accident 3 Suicide	investigati	on			M 1(]Yes 2□No					
ĭ <u>S</u>	frer d frect in by	Ē	4 Homicide	determine	d 286. Place of	Injury - At home etc. (Spacify)	, ferm,	street, factory, office	9	28f. Location (S City or Tow		er or Rura	l Route Number,	
	To the Hospital or Attending Physicien: within 24 hours fafer death of the Funeral Director: After this certific complataly filled in by the funeral director,		29a. Certifier	Certifying F	hysician: To the be	st of my knowle	doe dec	ath occurred at the	time date end place	and due to the	euse(s) and me	anner es et	eted	_
	e Hog	edicai	(Check only 2 one)	Medical Ex	miner: On the besis	of examinetion stated.	end/or	investigation, in my	time, date end place oplnion, deeth occu	rred et the time,	dete end piece,	end due to	the ceuse(s)	
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1	0	-	30. Name and eddres	s of person who	completed cause o	f deeth (Item 23	e) (Typ	e, Print)	1 2202		2	01	, 11/	_
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 99

					Certific	ate of	Death		Reg. No.		1001
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Physici /Medio		MABLE S	HARIF					11	23	70	0445
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Funeral Director		5. Social Security Number 241-34-4578 Usual Residence of Decedent	Sax 7. A	ge (In yrs. le 77		ns Days	Hours Min.			9. Birthol Coun	•
the Meryland 28a-f ehow		10e. Stete 10b. County		10c. City,	Town or Location					10	0d. Insida City I
r 28a-f ehow	Director	MD NA 10e. Street end Number		Bal	ltimore	Zip Code			10g. Citizen of	What Cour	1 💢 Yas 2
efter deeth witl or Items 23a o	Funeral	1217 West Fa	12. Wes Decedent Armed Forces	Evar in U,S	13. Wes De	212 cedent of I pecify Cub	123 Hispenic Orlgin? (S an, Mexican, Puer Specify:		U.S	e - America ck, Whita, a	en Indien,
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permit. Pa Departmen Important: any injury once.		21. Signeture of Funeral Sarvice Lic		n n	22. Name	end Addre	ess of Facility West				OWITY
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× 28 ×	Completed			-				24a. Wes perfo	en eutopsy med?	cor	ere eutopsy find alleble prior to appletion of ceu- deeth?
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Physician: The this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 E	R/Outpetient 3	DOA Ott	ner:	eth <i>(Check only o</i> Home 5 Resid		ner (Specify	()
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To the Hospital within 24 hours e To the Funeral I completely filled	edicai	29e. Certifier 12 Certifying F 2 Medical Exp	thysician: To the best aminer: On the besis of and menner st	f examinetic	edge, deeth occurr on end/or tnvestiget	ed et the ti ion, in my d	me, dete and plece opinion, death occu	e, and due to the durred et the time,	ceuse(s) end m date and plece,	enner es st and due to	eted. the ceuse(s)
Vithi To th	M	29b. Signature and title of certifier	Crde			DOO	54861		29d. Data signe		
9		30. Neme end address of person wh									
011	te	Robert Corder 31. Dete filed (Month, Dey, Year)	22 South 32. Begiste	Gre Gres Signatu	ene Str	eet,	Baltim	ore Mar	yland	212	201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Da 6:28PM Charlotte Elane Stafford NOVENDER 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 15c/videre 5. Social Security Number 2401 If Undar 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Davs Min. Hours 1□M 2X)F 64 219-28-2423 29 06 35 M.D Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2223 Tuckers Lane 21207 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1□ Yes 2□ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+yrs Audio Visual State of Maryland 12th grade Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George Colona Virginia Harris 19a. Informant's Name/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Grant-Sister 2831 Woodbrook Ave, Baltimore Md 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 12/3/99 Baltimore Co, Md 21. Signature of Fungrah-Benvice Licensee 22. Name and Addrass of Facility March F/H West 4300 Wabash Ave, Baltimore Md 23st. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximata Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2/1 No 281 No 1 Yas 1 Yes 25. Wes case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide

The law requires that the death certificate be executed the burial-tran and signed by the attending physician d be detached for use as the buria Box 68760 P.O. Division of Vitai Records. this certificate has

Physician

/Medical

Examiner

Director

Funeral

Completed by

8

Funeral

Director

or 28a-f

. Pages 1 and 2 should be till ment of Health and Mental H tant: If them 27 is marked oth

Department of Health Important: If Item 27

Physician

/Medical Examiner

na-loke

Physician/Medicai Completed by Be Certification: To

Examiner

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director,

State Registrar

DHMH 16 Rav 6/95

Medicai

rkupir (PN 31. Date filed (Month, Day, Year) DEC 02

4 ☐ Homicide

29a. Certifier (Check only one)

29b. Signature at

1-1050 171 32. Registrar's Signature 1999

(ddress of person who completed cause of death (ttem 23a) (Type, Print)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

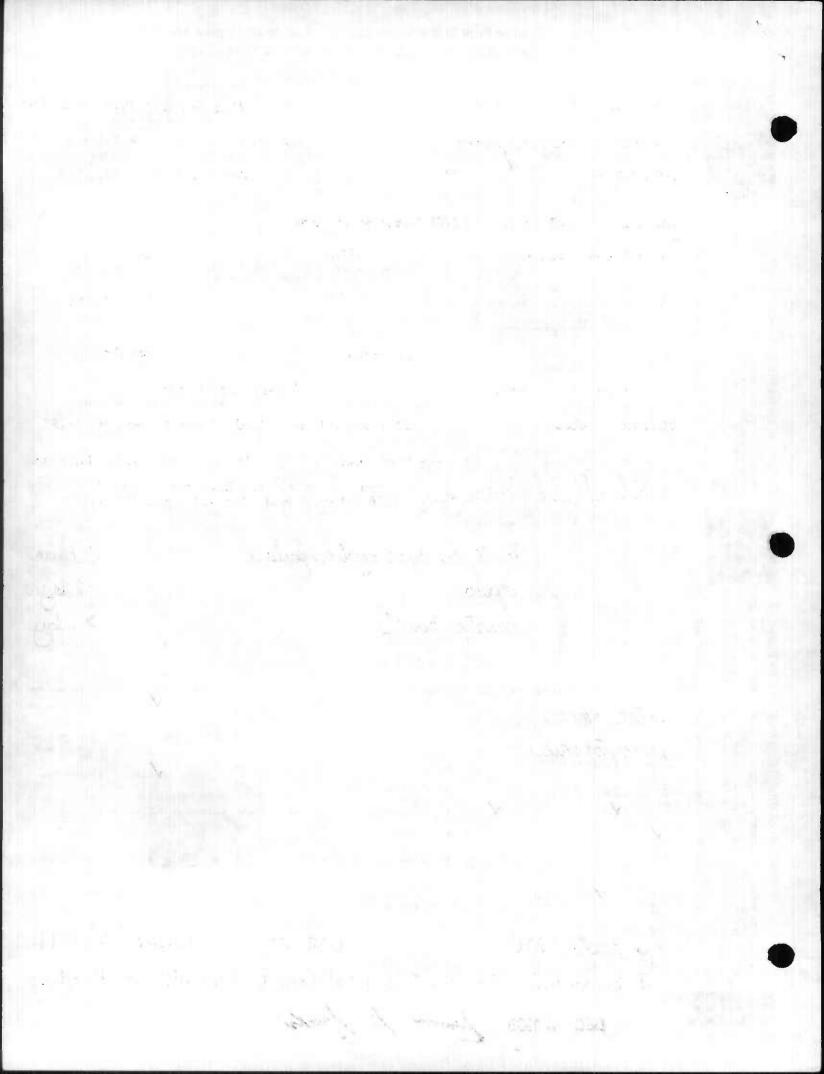
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** M Salemi 4:20FM Teresa November 25 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Sax **Funeral** Days Months 78 Mar 26, 1921 Director 218-09-0137 New York Usuel Rasidance of Dacedan the Marylend 10c. City, Town or Location 10e. Stata 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Directo Baltimore Maryland Randallstown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 3709 Stoneybrook Road 21133 U.S.A. death Funerai 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner m 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yes 25 No If Yas, Giva 14. Race - Amaricen Indien, 11 Maritel Status Bleck, White, atc. purmit. Pages 1 and 2 should be filed within 72 hours effer of the purple of the purpl 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced White Yeer or Dates: Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Own Home Unknown Homemaker 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) 8 Diorio Roche Margaret Clark 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Vincent 3711 Stoneybrook Road Randallstown, MD 21133 Salemi 20b. Plece of Disposition (Name of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 \$\overline{\mathbb{R}} Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 11/30 Sykesville, Maryland 21. Signature of Funeral Service Licensea 22. Nama and Address of Facility Loring Byers Funeral Directors, Inc. Min 8728 Liberty Road Randallstown, MD 21133 23a. Pert1. Enter the diseasa, or complications that causad the death. Do not anter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Deeth **Physician** Multiple organ system failure /Medical Immediate Ceuse (Final disaasa or condition rasulting in daath) Examiner Examiner physician and the bunal-transit the death certificate be executed Sequantially list conditions, if eny, leading to immadiate ceusa. Entar Undarlying Causa (Disaese or Injury that Initiated avants rasulting In deeth) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, bowe Physician/Medicai 80 ettending properties signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco usa contribute to the ceuse of deeth? 1 Yee 2 No 3 Probably 4 Unknown concer g 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed s certificate has director, page 2 2 M No 1 ☐ Yas 2 ☐ No 1 ☐ Yas or Attending Physician; Be 25. Wes cesa referred to medical axaminer? 26. Place of Daeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Panding 1 Yas 2 No deeth. invastigation efter deeth.

Director: A in by the for 2 Accidant 6 Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 24 hours efter Funeral Directions of the letter of the let 4 Homicida Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and dua to tha causa(s) and menner as stated. within 24 hot To the Fune completely fi (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and manner stated. 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signature and titla of certifier November 25, 1999 soston MO D28462 30. Name and addrass of person who completed ceuse of death (Itam 23e) (Type, Print) Center Randallstown Maryland Boston M.D Northwest Hospital 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura

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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death November 30, 1999 Anthony Tamanini 12:20 PM 4b. City, Town, or Location of Death 4c. County of Death Edgewood Harford If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Feb. 20, 1915 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) Deys Hours 1 M 2□ F 84 Yes 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Edgewood Harford 10f. Zip Code 10g, Citizen of What Country? 21040 U.S.A. 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: White

/Medical 4a Facility Name (If not institution, give street and number) Examiner 720 Pinefield Way 5. Social Security Number **Funeral** 171-03-6573 Director Usual Residence of Decedent 10a. State r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at Director Maryland 10e. Street and Number 720 Pinefield Way deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates; permit. Pages 1 and 2 should be filed within 72 hours effar i Department of Haalth and Mentel Hyglane. Important: if them 27 is marked other than "natural", or iter eny injury or other traumatic avent, the Medical Franch 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automobile Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 6th Grade Auto Assembly Worker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) B Henry Tamanini Victoria Daldon 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Clavey (daughter) 218 S. East Avenue, Baltimore, MD 20b. Place of Disposition (Name of cametery, crametory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 12/3/99 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Due to (or as a consequence of): Box 68760,

physician and s the burlal-transit

Physician

The law requires that the deeth certificate be executed this cartificeta has been a rai director, paga 2 should or Attanding Physician: Ne Hospital or Attanding n 24 hours efter death. Ne Funeral Director: After plately filled in by the fun

Division of Vital Records, P.O.

To the Hosp within 24 hor To the Fune completely fi State

Approximete Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown rochite þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed 1 Yes 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 1 Yes 3 No Cartification: To Masidence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Offatural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only

29d. Date signed (Month, Day, Year)

21236

40854

29c. License number

30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print)

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Bultimor

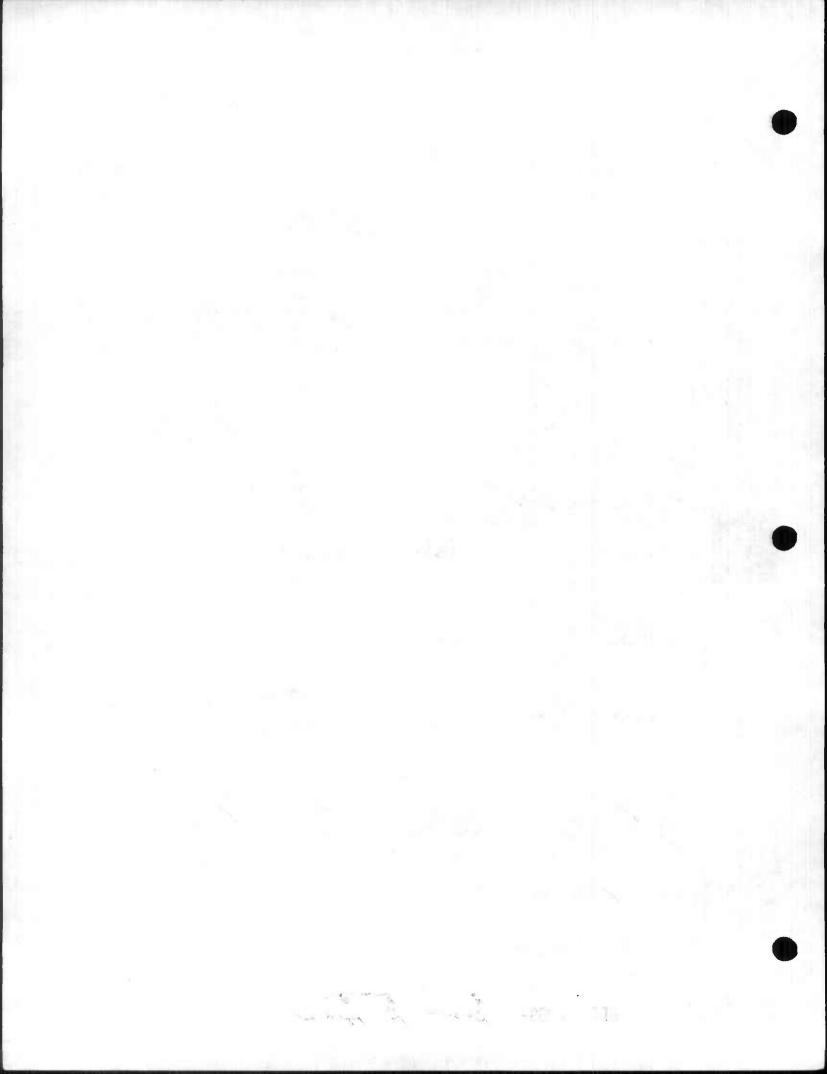
31. Date filed (Month, Day, Yellir)

29b. Signature and title of certifie

DEC



Registrar



Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV Month **Physician** DUISE E. TALLE 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE

If Under 24 Hrs.
Hours Min.

Min.

MAR 25 1939 424 MANSE COURT If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20€F Months Days 60 Yrs. Director death with the Maryland 10a. State Work ! 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at RALTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 424 MANSE COURT USA 21201 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or fee any injury or other traumatic avant, the Medical Examine Bods. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0020 1 ☐ Yes 2 SiNo Specify: py 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HILTON HOTEL College (1-4or 5+) HOUSEKEEPING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JAMES SHELLINGTON ALLUSTUS DUFFY 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. MO VALERIE TALLE 424 MANSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation Dec4, 1999 WOODLAWN, MD KING MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee TRYSTATE FUNERAL SERVICE

108 W WORTH AVE BALTO. MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximately a service of the serv 22. Name and Address of Facility 21201 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final multisystein disease or condition resulting in death) Examiner Examiner Neck CANCELL attending physician and for use as the burlal-transit or Attanding Physician: The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): P.O. F been signed by the should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 TYss 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 certificata 1 Yes 2 No 1 Yes 2 No Division of Vital funaral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier To the 29b. Signature and title of conflict. 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of pirmon completed cause of death (Item 23a) (Type, Print) KENNEDY ANDREW MD

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, (Sear)

1999 37. Registrer's Signature

Court of State of the State of A Think I We FOREST STREET, STREET ed a street of The second second was a second for the contract of the second Management of the party of the text of the tree of the second The transfer of the first of th

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 17,18 per fh G779 1/12/00 yg Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** WITHERSPOON 8:n Am THELMA /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Baltimore
If Under 24 Hrs. 8. D Bon Secours
5. Social Security Number Hospital If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Min. Deys Hours Months 1□M 2X)F 78 S.C Director 216-24-3025 06 06 Usual Residence of Decedent ahow. 10a. Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f ahor Director Wes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1950 West Fayette Street 21223 U.S.A. death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiena. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic avent, the Medical Esaminan Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried 20 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: p 3 Widowed 4 Divorced Black Completed 16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Private House Keeping 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Ida Golden Lee Israel Whitherspoon Sarah Lee 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1950 West Fayette St. Baltimore Md 21223 <u> Ida Witherspoon-Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 D'Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 12/01/99 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility March F/H West 4300 Wabash Ave, Baltimore Md at cause the death. Do not enter the mode of dying, such as cardiac or respiretory errest. 21215 Approximet cations that cau Interval Between Onset and Deeth **Physician** /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or ea a con Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): USB BS ! The law requires that the death P.O. Part I. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknown Records, Ś 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en eutopsy 1 Yes 1 Yes of Vital Physician: 25. Was case referred to medicel examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Denpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred 1 Netural
2 Accident 5 Pending investigation I aftar death. Il Diractor: Af ed in by the fu 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide

Division or Attending To the Hospital of within 24 hours at To the Funeral Completely filled in

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DHMH 16 Rev 6/95

State Registrar

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29e. Certifier

31. Date filed (Month, Day Year DEC 02

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29b. Signature and title of certifie

30, Name and address of pe

32. Registrar'a Signatu

pleted cause of death (Ite

NO

29c. License number

29d. Date signed (Month, Dey, Year) 26

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23a) (Type, Prin

from the opening

DEC 0 2 1999

Box 68760. P.O.

Examiner Physician/Medical þ Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

or 28s-1 st be notified

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Derma.

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

Department

Physician /Medical

Examiner

or other traus

AGA: WILLIAMS, JOSEPH E Baitimore, Maryland 21215-0020

Directo

Funeral

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Completed

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The law requires that the death certificate be executed bunal-transit the th 60 60 nse certificate or Attending Physician: funeral director, this To the Hospital or Attended:
within 24 hours after death.
To the Funeral Director: Aft

Division of Vital Records,

State

Registrar

Medical

au.

Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

D14958

1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DECEMBER 1, 1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

AURORA C. TAN, MD, VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052

31. Date filed (Month, Day, Year) 1999

Mora

3 ☐ Suicida

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

6 Could not be determined

32. Registrar's Signeture

the state of the same

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

37689 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Dev Year **Physician** JOSEPH SAMUEL ARNONE NOVEMBER 20 1999 10:20 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 7. Aga (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours 214-05-5917 1⊠M 2□ F Months **Director** 15 1907 MARYLAND Usual Rasidence of Decedant 10a Stata 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show the Maryta must be notified at MARYLAND ALLEGANY CUMBERLAND 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code t0g. Citizen of What Country? "natural", or liente 23a or 21502 135 NORTH MECHANIC STREET U.S.A. Funeral Raca - American Indian, Bleck, Whita, etc. 12. Wes Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) alte. Yes 2 No 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Yas Giva Specify: WHITE À 72 hours 3 ₩ Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important; if them 21 is marked other the 8 FOOD/SALESMAN WHITMER FOODS/SALESMAN 17. Father's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) Be CONCETTA GUALTIERI 2 LUIGI ARNONE 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MICHELE CRABTREE GRANDAUGHTER 1037 FREDERICK STREET CUMBERLAND MARYLAND 21502 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata SUNSET CEMETERY NOV 24 1999 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licent 22. Nama and Address of Facility
MERRITT-ADAMS FUNERAL HOME P.A. O eint 404 DECATUR STREET CUMBERLAND MARYLAND 23e. Part1. Entar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Interval Batween Onset end Death **Physician** /Medical Immediata Causa (Final diseese or condition rasulting in death) ACUTE PULMONARY EDEMA 2 DAYS Examiner Due to (or as a consequence of): Examiner 5 YEARS AORTIC STENOSIS certificate be executed physicien end s the burial-trans Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): 10 YEARS Box 68760, CORONARY HEART DISEASE Physician/Medical Dua to (or as a consequence of) USB as 1 attending p for use as The law requires that the death Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the 3 Probably 4 Unknown 2 1 Yes 2 No signed t SEVERE ANEMIA by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed peen **pege 2** 1 Yas 2 No certificate 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28e. Data of Injury (Month, Day Year) funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural or Attanding 5 Pending invastigation death. 1 Yas 2 No 2 Accident Director: 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Yown, Stata) 3 after 4 Homicide Euneral Directory affects
 Funeral Directory filled in b 29e. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date end plece, and due to the causa(s) end manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner staffed. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura end titla of certifie 5 M.D D 23334 NOVEMBER 2019 1979 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) DINESH SHAH M.D., 625 KENT AVE., CUMBERLAND, MD nus 21502 SUITE 205 31. Dete filed (Month, Dey, Year) 32. Registrar's Signatura State NOV 2 2 1999 Registrar

DHMH 16 Rev 6/95

214-05-5917

JOSEPH ARNONE

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Burdette, Sr. John Henry 12:50AM November 16, 1999 /Medical 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 4105 Teklen Drive Westminster 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Nov 29, 1918 6. Sex 1D M 2□ F 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 235 - 05 - 0073 Yrs Director 80 West Virginia Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 7 is marked other than "natural", or itama 23e or 28a-f show treumatic evant, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Westminster Maryland Carroli 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4105 Teklen Drive USA permit. Pages 1 and 2 should be filed within 72 hours after death.
Department of Health and Mantal Hygiene.
Important: If Item 27 is marked other than "natural", or Itema 23s, eny injury or other treuments access 21157 12. Was Decadent Ever In U,S. Amed Forces? 1 ½ Yes 2 □ No If Yes, Give Year or Detes: 1942–1945 13. Was Decadent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Stee Coal Line Worker 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Offa Burdette 2 Nannie Carver 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4105 Teklen Drive Westminster, Maryland 21157 Wilda D. Burdette/wife 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removel from State Sykesville Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Lake View Memorial Park 11/20/99 21. Signature of Funerel Service Licenses 22. Name and Address PLF Silly Zumbrun Funeral Home & Monument Co. 6028 Sykesville Road Eldersburg, Maryland 21784 er the disee heart failure or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** WNG /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner certificate be executed attending physician and I for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of) signed by the at d be datached for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of deeth? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, b 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy been After this cartificate has 2 000 1 Yes 2 No 1 Yes filled in by the funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 100 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pi 24 hours after death. Funerel Director: After the Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and pleca, end due to the ceuse(s) end menner steted. 29a. Certifier edical (Check only one) 29b. Signature 29d. Date signed (Month, Dey, Year) 29c. License number le of cartifie D35398 11/17/99 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Flavio Kruter 684 Poole Road Westminster, Maryland 21157 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature books NOV 1 7 1999

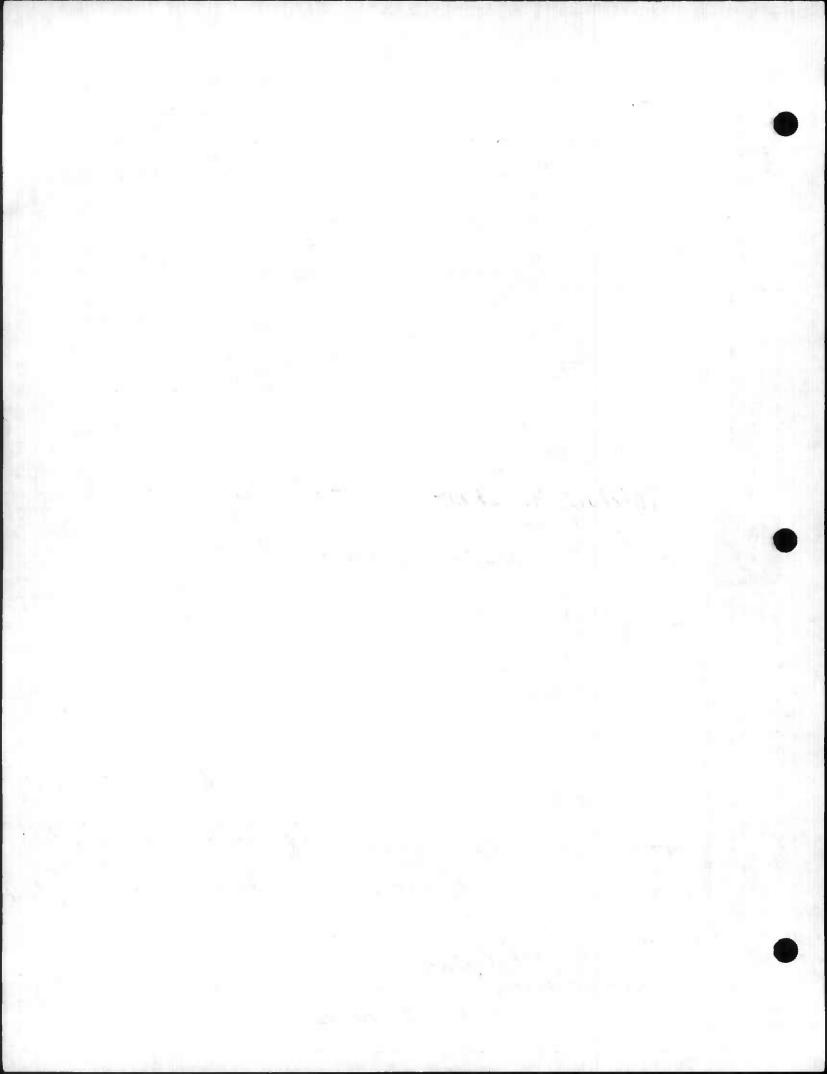
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	Examir		4a Facility Neme (If not institution	, give street and number)			4b. City, Town, or L	ocation of Death	4c. County of D	
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	Funeral Director		5. Social Security Number	10X M 2□ F	e (In yrs. last b	Yrs. Months Days		8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
			Usual Residence of Decedent					Sept.1	3,1972	Maryland
	anyler	7	10a. Stete 10b. County	14		wn or Location				10d. Inside City Limits 1 ☐ Yes 2 💢 No
	the Marylen 7 28e-f ahow notified at	Director	MD Caro	line	P	reston 10f. Zip Code		1	0g. Citizen of What	
	death with the Maryland ms 23a or 28a-f show must be notified at	O	6206 Harmony	Road		101. 2.19 0000	21655		Jnited S	
		Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Wes Decedent of If Yes, specify Cut	Hispanic Origin? (Sp	ecify Yes or No-		merican Indien, fhite, etc.
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2	N 0 0 2		19a. Informant's Name/Relationsh Deborah Ann F			b. Mailing Address (Stree				
a,	r Haalth Hem 27 I		20a. Method of Disposition		20b. Plece	6206 Harm (of Disposition (Name of ery, cremetory or other ple		Prestor	20c. Location - City	or Town, State
Ë,	Page mrt: if iry or		1 🖾 Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (Sp			or Order (11-27	Prestor	MD
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	ysiciant: The last sector, page director, page	Bec	25. Was case referred to medical examiner?				26. Place of Daa		22	19.00
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	the F	Med	one)	and manner ste	eted.					
	O T V O	-	29b. Signature and title of certifier	,111		29c. Licen	se number	2	9d. Dete signed (M	onen, Day, Year)
			30. Name and address of person w	- U.K.	Jung		.M.E	No	OVEMBER 2	2,1999
			THEYOULE	no completed cause of b	mui (meni 23a)	C. 33	n Street,	Baltimo	re. Marvl	and 21201
	Sta	te	31. Date filed (Month, Day, Year)		nr's Signature			Jul Carry	, intry1	LIEVI
	Registr	ar	NOV 2 4	1999	cean	A. Sport	2/1			

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State of Maryland / Department of Health and Mental Hygiene 9 9 37692

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21215-0020	naturel;	15.	Decedent's Ed			Sa. Decede	nt's Usuet (Occupa	ation			16b. Kind of	Business/Inc	dustry	
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Division	To the Hospital or Attending Pi within 24 hours effer death. To the Funerel Director: Affer it completely filled in by the funeral Medical Certification:	2 Accident 3 Suicide 6 4 Homicide	investigation Could not be determined	288. Place of	Injury - At home, etc. (Specify)	farm, stree	M et, fectory, o		Yes 2⊡No		8f. Location (S City or Tox	Street and Nur m, State)	m <i>ber or Rurs</i>	al Route Num	iber,
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State of Maryland / Department of Health and Mental Hygiene

37693 Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Date of Death 3 Time of Death Month 17, 1999 **Physician** MARY LOUISE WARD BODEK November d: 10 am /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Tawes Nursing Home Crisfield Somerset 5. Social Security Number 7. Age (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** 1 M 2XF Months Days Hours 216-48-5327 89 Yrs. Director April 15, 1910 Maryland Usual Rasidance of Decedant with the Maryland 10a, Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show r than "natural", or Itams 23s or 28s-f st the Modical Examiner must be notified Maryland Somerset Crisfield 1 TYPYAS 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 19 W. Chesapeake Avenue 21817 U.S.A. Funeral death 12. Was Dacedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaer or Datas: Was Dacedant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. filed within 72 hours efter 1 Navar Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White λq 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry I Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) Grade 11 Practical Nurse Medica1 traumatic evant. altimore, Maryland 17. Fether's Nama (First, Middla, Last) . Pages 1 and 2 should be fill ment of Health and Mental Hyant: If Item 27 is marked oth jury or other traumatic evant 18. Mother's Nama (First, Middle, Maiden Surnama) George L. Ward Mary Sterling 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Steta, Zip Coda) Richard B. Ward (Cousin) 31222 Rehobeth Rd. - Westover, MD 20b. Place of Disposition (Name of camatary, crametory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, State 1 28 Burial 2 Cramation 3 Ramovel from Stata Department of important: If eny injury or once. Crisfield Cemetery 11/20/99 Crisfield, MD 4 Donation 5-2 Othar (Spacify) 21. Signature 22. Nama and Addrass of Fecility Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr 306 W. Main St.- Crisfield,

23a. Part1. Enter the disease, or complications thet ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. 306 W. Main St.- Crisfield, MD Approximata Intarval Batwaen Onset and Death Physician /Medical Immediata Cause (Final bleeding disaase or condition resulting in daath) **Examiner** Dua to (or as a consequence of) Examiner The lew requires that the death certificate be executed burial-transit Saquantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseesa or injury that initieted evants resulting in daath) Last pue Due to (or as a consequence of): Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were sutopsy findings evelleble prior to complation of causa of daath? 24a. Wes en eutopsy performed? this certificate has 2 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: ofter death.

Director: After this certifica Be 25. Was casa raferred to medical 26. Placa of Death (Check only ona) axaminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yas 2 No Othar: 4 Nursing Homa 5 - Rasidance 6 Othar (Specify) 0 28a. Data of Injury (Month, Day Year) Certification: Manpar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Naturel 5 Panding 2 Accidant invastigation 1 Yas 2 No 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stete) 24 hours efter de • Funeral Directo letely filled in by t 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida edical Cartifying Physician: To the best of my knowledge, death occurred at tha time, deta and piece, and due to the ceuse(s) end manner as stated.

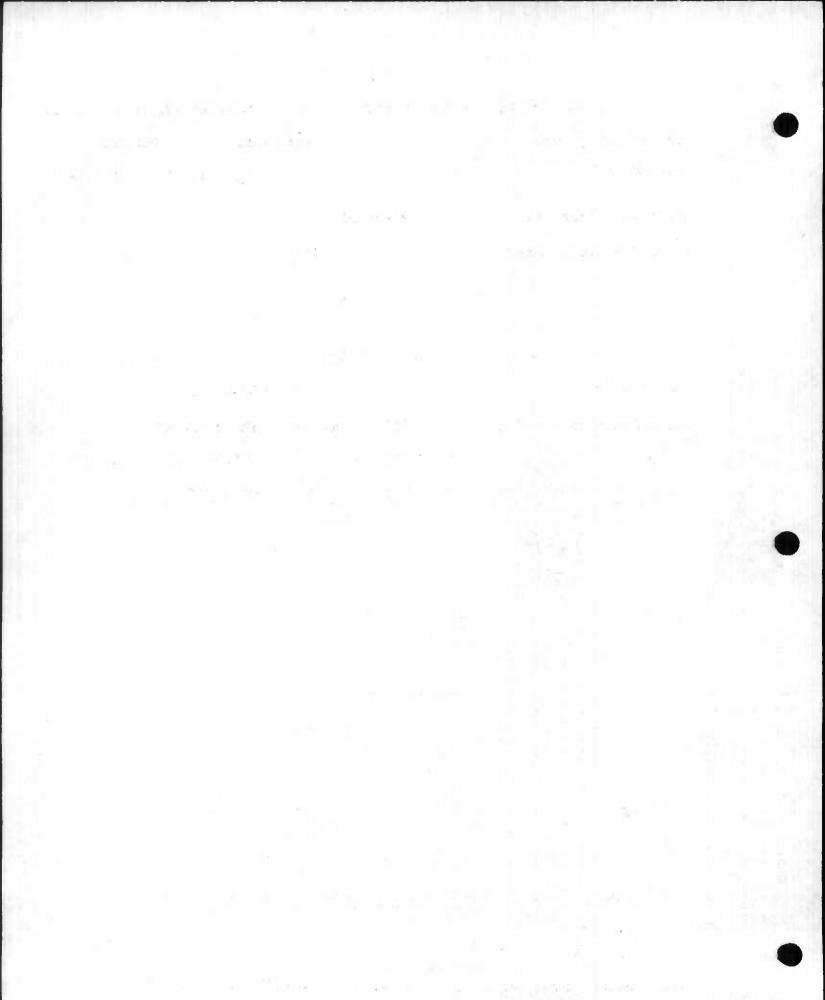
Medical Examinar: On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, date and piace, and dua to tha cause(s) and mannar stated. 29e. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 480 98 55 . 30. Neme and address of person who completed cause of death (Itam 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 31. Deta filed (Month, Day, Year) 32. Registrer's Signatura

G. Sparky

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene QQ Amended Item#10g, 11/23/1999, FCHD, KS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 18, 1999 Margaret Elton Booker 3:55 am Jospehine 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Homewood Retirement Center Frederick Frederick If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days 212-28-2450 1 M 2 F 89 Yrs. Jul 06,1910 NorthernIreland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Great 31 West Patrick Street 21701 14. Race - Amaricam Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2000 If Yes, Give Year or Dates: 1 Yes 2√ No Specify: Specify: White **\$**\$\text{Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Elton. Benjamin Whitmore Eleanor McDonald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs Norma Maile/Sister 7210 Rainbow Lane, Frederick, Maryland 21702 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Steta 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State Bethel Cemetery Nov 20, 1999 Chesapeake City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home Kutherson M00706 106 East Church St, Frederick, maryland 21701 Approximata Intervel Between Onset end Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, about, or heart feilure. List only one cause on each line. brounsca las Accide Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequence of) Due to (or es e consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

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To the Funeral Director: Aftr completely filled in by the fur

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Pages 1 and 2 should be filed within 72 hours etter deeth with and of Heelih and Mentel Hygione.

In it from 27 is marked other than "natural; or frome 23a or inly or other thaumatic event, the Media.

Baitimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2000 1 Yes 2 No

25. Was case referred to medical 1 Yes 2 We 27. Manner of Death 1 Accident

Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

26. Place of Deeth (Check only one)

Other: 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier

3 Suicide

4 Homicide

The continuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

20b. Signature and life of certifie

5 Pending investigation

6 Could not be

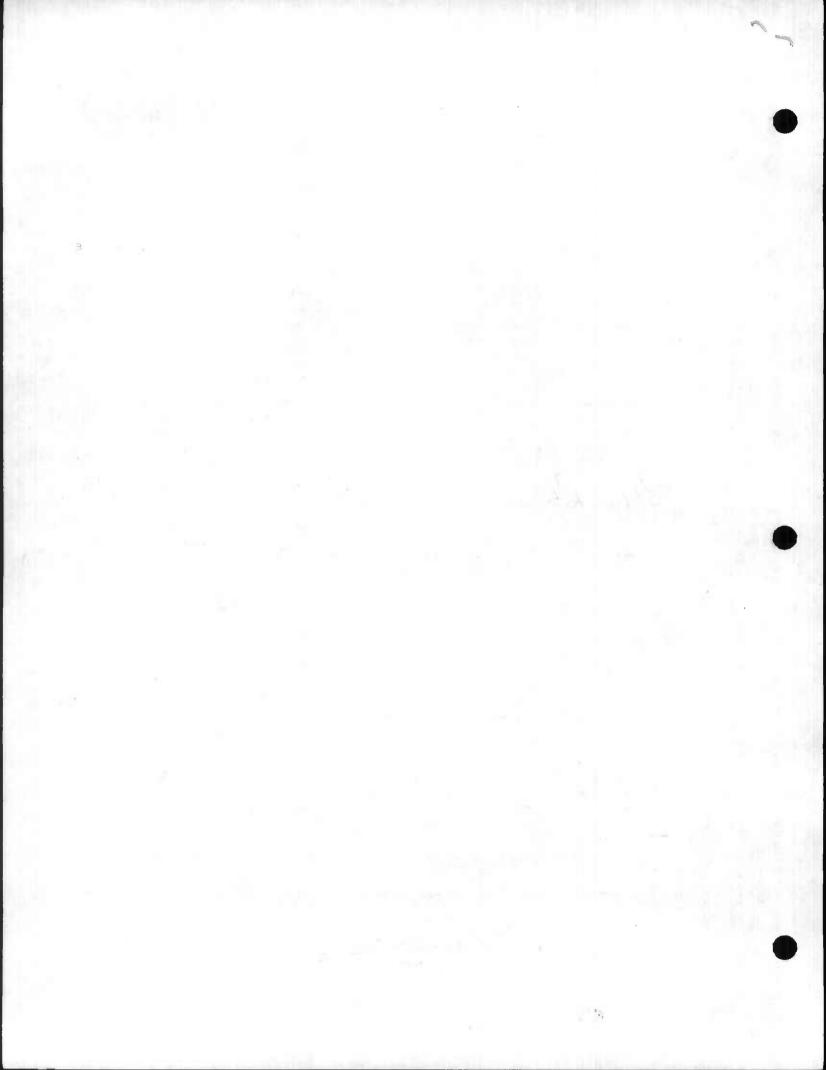
29c. License numbe

29d. Date signed (Month, Day, Year) November 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline, M.D., 300 West Ninth Street, Frederick, Maryland 21701 III 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

Registrar



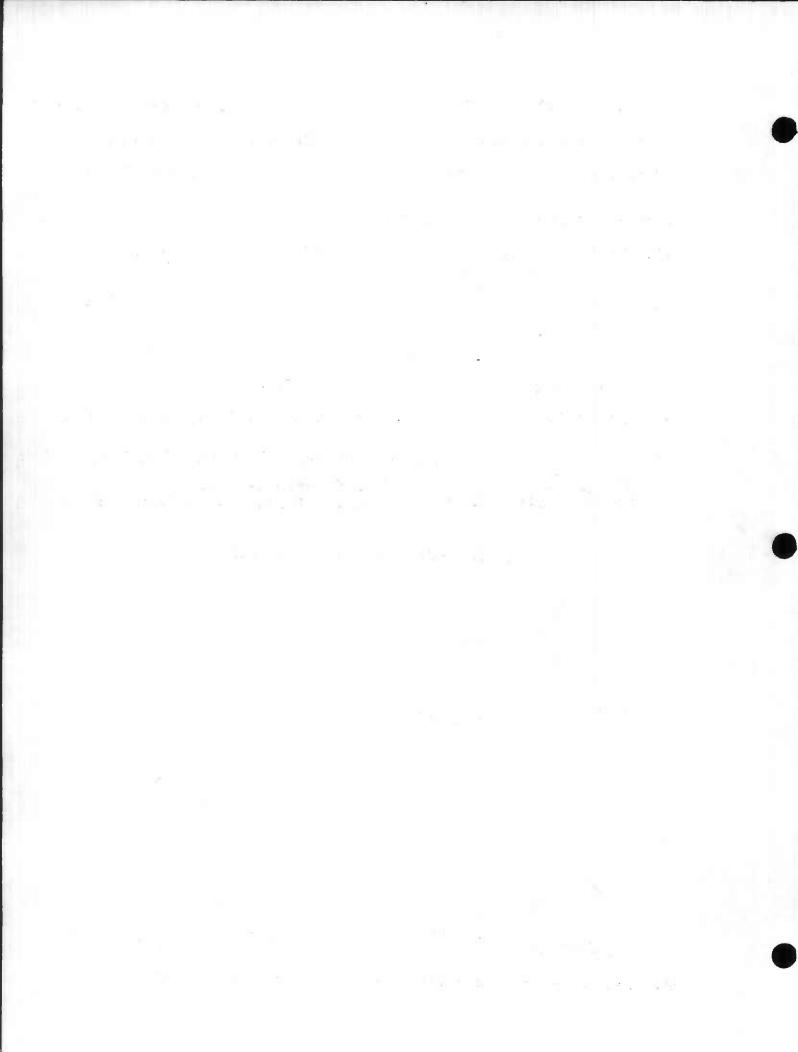
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth **Physician** Month FDWARD WILLIAM BURCH Nov. 18, 1999 1:16 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nema (If not Institution, giva street and number) Examiner 7180 Carrico Mill Road Hughesville Charles If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. Feb. 15, 1916 6. Sex 1 M M 2 □ F 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. 83 Maryland **Director** 217-36-5617 Usuet Residence of Decedent with the Maryland 10e. Siele 10b. Count 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Charles Hughesville Maryland 10f. Zip Code 10g. Citizan of Whal Country? 10e. Streel end Number 20637 U.S.A. 7180 Carrico Mill Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene, and instruction of Health and Mental Hygiene, and instruction of them 23a important if item 27 is marked other than "natural", or itema 23a and injury or other traumatic event, the Medical Exercises. Funeral 12. Was Dacedani Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Give Yeer or Deles: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - Amarican Indian Black, While, etc. 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Farmer Agriculture 8 18. Molher's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Claudia Dyer Bernard Burch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 3066 Endicott Court, Waldorf, Maryland 20602 Carl E. Burch/Son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slete 20e. Method of Disposition 1

Buriel 2 □ Cremellon 3 □ Removel from State
4 □ Donellon 5 □ Other (Specify) St. Mary's Cemetery 11-22-1999 Bryantown, Maryland Feneral Service Liberse 22. Name end Address of Fecility
Huntt Funeral Home, Inc. JOHN P. KNISLEY M01164 P. O. Box 156, Waldorf, MD 20604-0156 mew 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsel and Deeth **Physician** Immediale Cause (Final disease or condition resulting in deeth) /Medicai CARDIOVASCULAR DISEASE Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) SE USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 □ Probably 4 □ Unknown CARDIAC DYSRHYTHMIAS þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed has e 2 certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician:
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DHMH 16 Rev 6/95



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Expired november 15,1999 @ 1430.

Berriman, Richard

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 37697

							Certific	ate of	Death		8	leg. No.		1001
		1. Decedent's Name (First, Mi	idie, Las	1)							2. Dete of Dea Month	th Dey	Year	3. Time of Deeth
Physicia /Medica		Delphia R. B	11								Novembe		1999	6:50 PM
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Funeral		5. Social Security Number	6. Se	M 2XF	7. Age (In yrs		Mon	nder 1 Yea		24 Hrs. Min.	8. Dete of Birth (Month, Day	Year)	9. Birth Cou	place (State or Foreign intry)
Director		227-28-4235		JW ZML	74	Y	rs.				October			irginia
Pu s		Usual Residence of Decedent 10a. State 10b. Cou	ıtv		10c C	ity Town	or Location							10d. Inside City Limits
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Baltimore, Normit. Pages 1 and Spatiment of Health Important: If leath Important: If lists 27 inty Injury or other transce.		20a. Method of Disposition				Place of	Disposition	(Name of			Date		on - City or T	
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Division or To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completally filled in by the funeral	edical	one) 2 Medic	ai EXAMI	nar: On the ba and mann		ation and	vor investige	ation, in my	opinion, dea	sin occur	red at the time, o	ate and pla	ice, and due	to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 9 9 3 7 6 9 8

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xaminer		Facility Name (If not institute		et and numi	ber)				4b. City, Tov	wn, or Lo	cation of Dea	ith 4c	. County	of Deeth		
	10	66 Hopewell R	Rd.						Risino	a Sur	ı	(ceci	l		
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DHMH 16 Ray 6/95

SECT S A MON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amended Item 19a, 11/30/99, Certificate of Death 1. Decedent's Name (First, Middle Lust) Cecil Co. 2. Date of Death 3. Time of Death Month Physician Dorothy Dickerson Baker 2020 November 20 /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Union Hospital of Cecil County E1kton Cecil 8. Date of Birth (Month, Day, Year) Aug. 5, 1914 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) 9. Birthplaca (State or Foreign **Funeral** Maryland Days 1 M 2KTKF Months Hours 216-20-1260 85 Director Usual Residenca of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at Cecil 1 X Yes 2 □ No Director Maryland Perryville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1025 Aiken Avenue 21903 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. hours after 1 Never Married 2 Married ☐ Yes 20XNo f Yes, Giva altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ ₩idowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Harford County Board of Education Hygiene. College (1-4or 5+) Six Years Elementary/Secondary (0-12) School Teacher Bel Air, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Peges 1 and 2 should be 1 nent of Health end Mentel I int: If Item 27 is marked or C. Windsor Dickerson Vera Giles Collins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2:
Department of Health or
Important: If Item 27 is
any injury or other trau Doris Blevins (Niece) 393 Baron Road, North East, Maryland 20a. Method of Disposition 20b Place of Disposition (Nama of Date 20c. Location - City or Town, State mentery, crempatory or other place)
ew London Presbyterian 11/24/99 New London, Pennsylvania 1 Burial 2 □ Cremation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvica Licansee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home titlehoon, Sr. Perryville, Maryland 21903-0188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Causa (Final disease or condition resulting in death) Examiner Examiner physician end s the buriel-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that better Box 68760, Physician/Medical that initiated events resulting in death) Last use as the Due to (or es e consequença of): ettending p P.O. 1 Pert il. Other significent conditions contributing to death but not resulting in the underlying cause givan in Part i. 23b. Did tobacco use contribute to the cause of death? the 2 40 Onknown 1 Yes 2 No 3 Probably Records, þ 24b. Wera autopsy findings evelleble prior to Completed 24a, Was an autopsy performed' completion of cause of death? has 20 No certificate 1 Yas 1 Tyes 2 No Division of Vital Hospital or Attending Physician: 25. Was casa raferred to examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Yes 200 Inpatient 2 ER/Outpetienf 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? After Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Investigation Injury To the Hospital or Attandir within 24 hours after death.
To the Funeral Director: Af complately filled in by the fu death. 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only Ž 29b. Signature and title of cartifier 29d. Data signed (Month, Day, Year) ited cause of death (Itam 23a) (Type, Print) Bagistrar's Synature State Registrar

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Helen 99 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number Hills Center Centreville Queen Anne Co. Corsica If Under 1 Yaar If Undar 24 Hrs. Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 217-36-0367B 1□ M 2反反 Yrs. 87 Oct. 16, 1912 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Md. Oueen Anne's Queenstown 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? U.S.A. 616 Stagwell Road 21658 14. Race - American Indian Black, White, etc. 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 Navar Married 2 Marriad 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: White 3⊟Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Delora Wolf Delmer Harner 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Tim Bishop 532 Stagwell Rd., Queenstown, Md. 21658 Nov. 6, 1999 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition ★Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Chesterfield Cemetery Centreville, Md. 22. Nama and Address of Facility 21. Signatu Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md. I caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate interval Between Onset and Death 23a. Part1. Enter shock, or he My e lodgsplasia and Due to for as a consequence of hvombog to penia tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other eignfficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown Siezure disorder Chronie pain Syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Avascular hecrosisy hips 1 Tyes 2 No 1 ☐ Yes 2 ☐ No. 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 PNatural 1 ☐ Yes 2 ☐ No

Physiclan /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

Director

Funeral

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Completed

Be

r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at

with the Marylend

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filed within 72 hours after

al Hygiene.

Department of Health end 2 should be Department of Health end Mental Important: If itam 27 is marked or any injury or other traumatic ever

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital Attending Physician: sician and burial-transit

Physician/Medical þ Completed Be P

edical

2 Accident 3 Suicide

4 Homicide

31. Date filed (Month, NOVar)

29a. Certifier

Examiner the as been signed by t Certification: To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Af

this certificate

Aftar

5 Pending investigation

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. Licanse number

29b. Signature and title of certifie

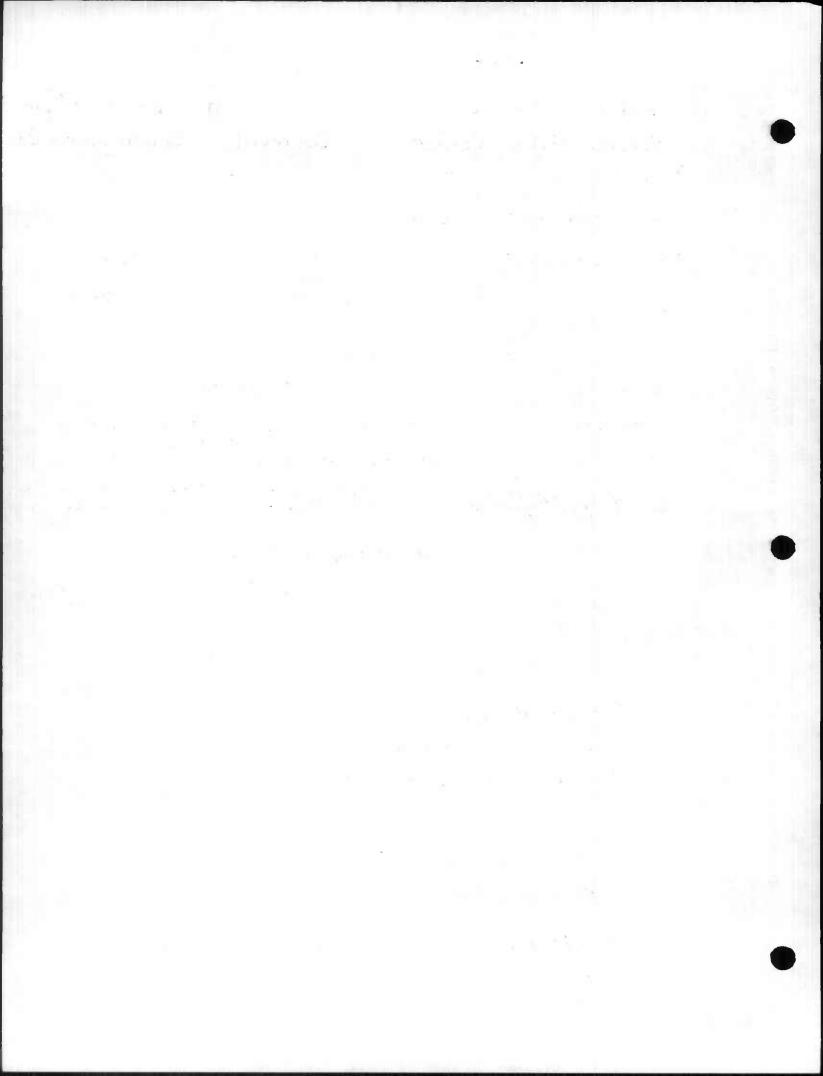
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29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

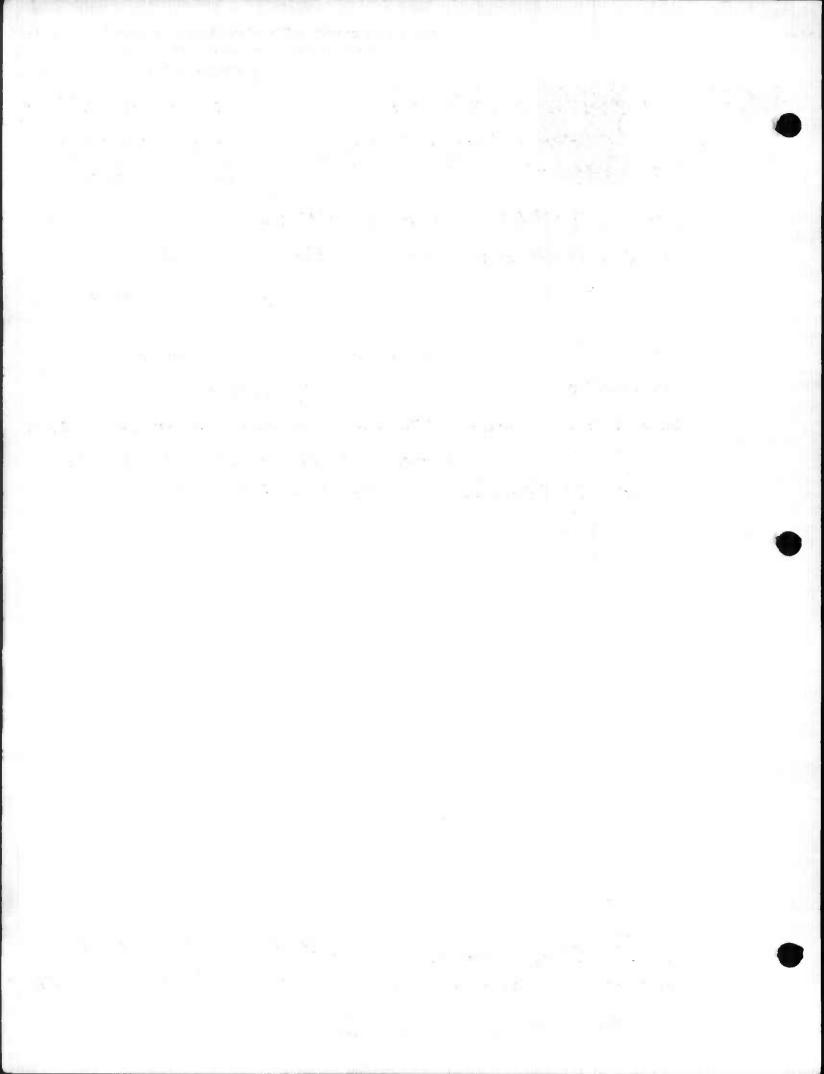
RUSSELL A Schuling B 2540 Contract 2540 Centreulle MD Centrelle MD 2167. 1999^{32. Registrati's Signature}

State Registrar



State of Maryland / Department of Health and Mental Hygiene qq

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V	Physici /Medic		1. Decedent's Neme (First, Middle, Las MITCHELL	L A. CHR	IST,	IAN			2. Dete of De Month	Dey /O	99	3. Time of Death 305 PW
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	Funeral Director		5. Sociel Security Number 6. Sociel Security Number 6. Sociel Security Number 1. Sociel Security		4-	Yrs. If United Month	der 1 Yeer hs Deys	If Under 24 Hrs Hours Min	. (Month, D		9. Birthpla Countr Maryl	ace (Stete or Foreign ny) and
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21215-0020	within ane. than	Completed	15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12)	ucation de completed) College (1-4or 5+)		Decedent's U (Give kind of life. DO NOT		pation during most of wo d)	orking	16b. Kind of Bu		istry
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Maryland	d 2 should be filed thend Mental Hyg 7 Is marked other traumatic svent,	To	John Christian						n Grupp	•		
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Division	or At after of Direct	Certification:	3 Sulcide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, fa	rm, street, fac	tory, office			(Street end Numb own, Stete)	er or Rurel	Route Number,
	Hospi 24 hou Funer tely fill	edicai	29a. Certifier (Check only one) 1 Carttfying Phy	reiclen: To the best of my liner: On the bests of exam	nowledge inetion en	, deeth occurr d/or investiget	ed et the ti	me, dete end ptec opinion, deeth occ	e, end due to the urred et the time	ceuse(s) end me , dete end place,	enner es ste end due to	eted. the ceuse(s)
	To the Hospital or within 24 hours after To the Funeral Dir complately filled in	Med	29b. Signature and tale of certifier	end menner stated.		1	29c. Licens		-	29d. Dete signe		
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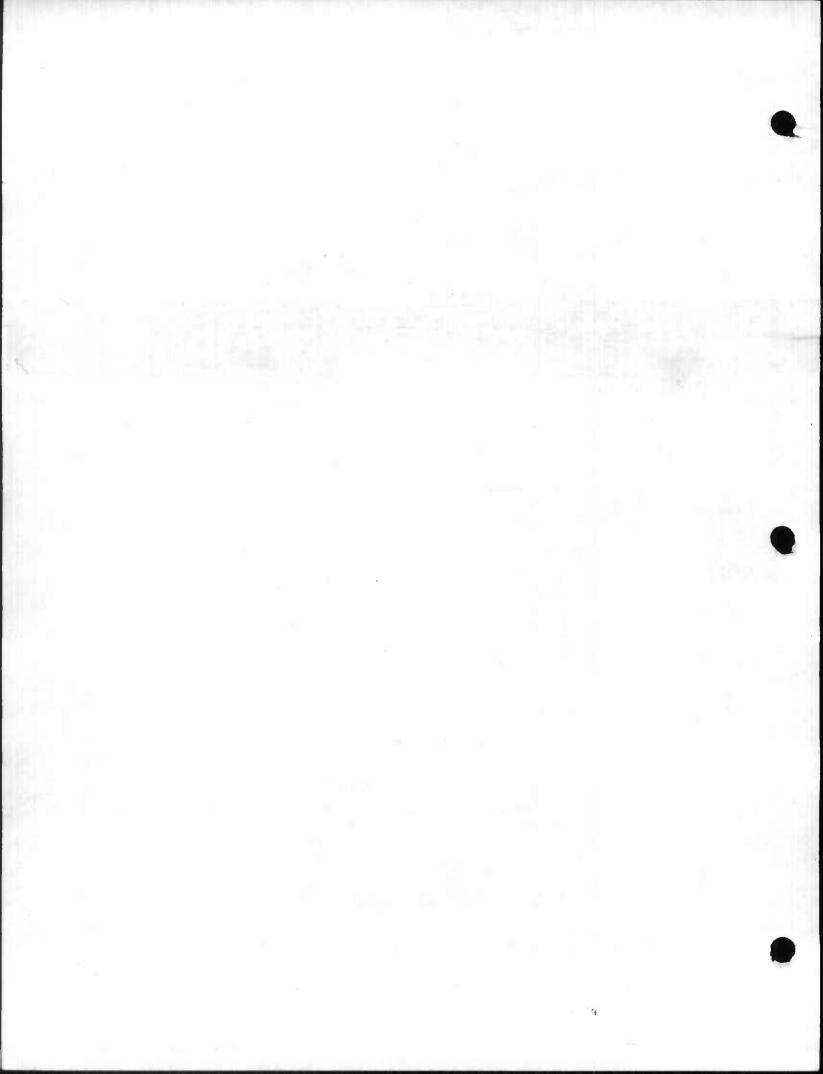


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 16 1999 Leo Arthur Carignan 1:56 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 31, 23 5. Social Security Number 6. Sex 1) M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Yes 76 Connecticut Director 044-18-9717 Usual Residence of Decedent 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show with injury or other traumatic event, tra Medical Examination to a north of all pages. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1) Yes 2 No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 32 E. George St. United States Funeral Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 43-46 Specify: à 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Lab Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Oliver Ρ. Carignan Marie 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy O'Neill Carignan/ wife 32 E. George St./ Walkersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glade Cemetery 11-20-99 Walkersville,MD 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike/ Frederick, MD. 21702 Approximate Interval Between Onset end Death **Physician** ACUTE ATRIVAY PROBLEM /Medical Immediate Cause (Final disease or condition resulting in death) Examiner TRACHEDSTVMY FOR RESP FAILURE Examiner physician and the bunal-transit Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FAILURE POST OP Box 68760 Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? RENAL FAILURS 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? VENTILL ATM DEPENDENT 24a. Wes en autopsy performed? Completed 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) axaminer?
1 Yes 2 No

27. Manner of Death
Natural
Accident Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation hours after death. 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier within 24 hor To the Fune completely fi (Check only 29b. Signetu/d and title of cerulie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul McNeill 400 W. Seventh St./ Frederick, Maryland 31. Date filed (Month, Day, Year) 17 1999 32. Registrar Signeture

DHMH 16 Rev 6/95

State Registrar

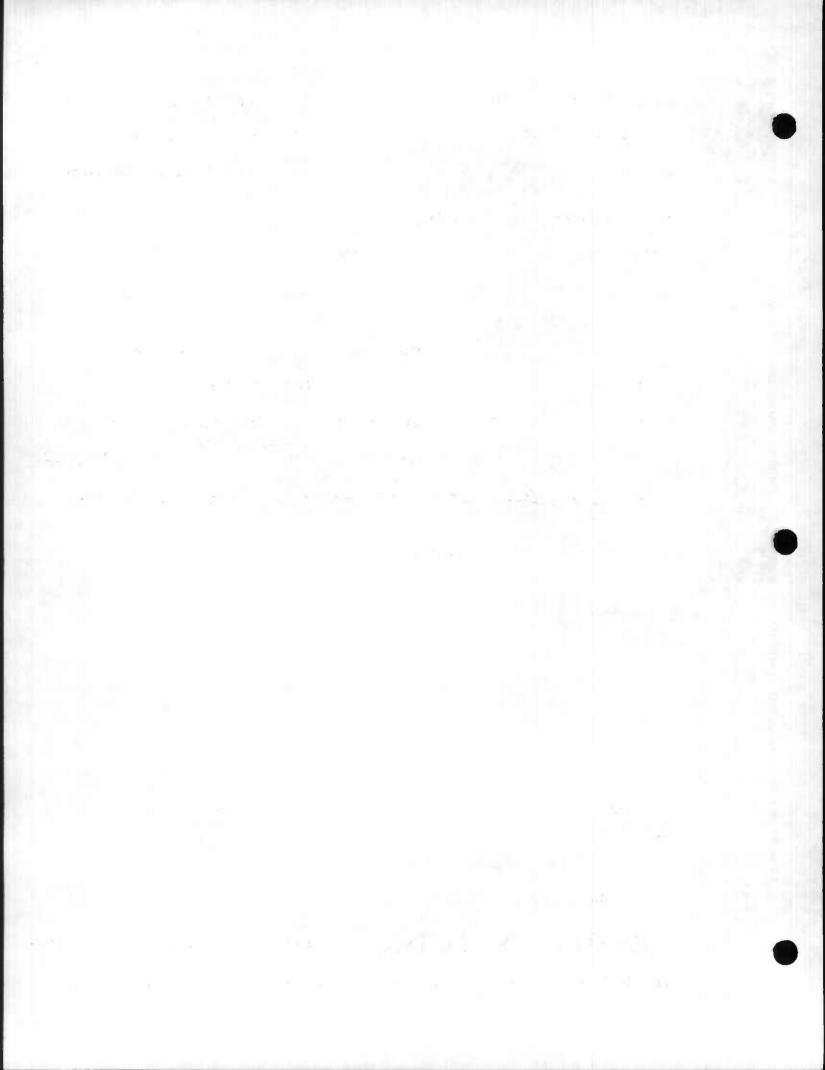


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Social Security Number 6. Sex 7. Age (m.yrs. Matchinolay) Bluder, Val.	miner	46 Facility Neme (If not institution, g	ive street and number	r)			- 1	tb. City, Town, or	Location of Deati	4c. Count	y of Deeth	
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George Naujokas Sr. 19e. Informents NemePietionchip (Type, Prot) William B. Clark/Husband 20e. Method of Disposition 1DiBuriel 2 Cremetion 3 Remove from State 4 Doneton 5 Other (Specify) 21. Signature of Function Scott (Park) 22. Signature of Function Scott (Park) 23. Place of Disposition (Name of Certainty), Greenedory of other place) 24. Service Licensee 25. Signature of Function Scott (Park) 25. Signature of Function Scott (Park) 26. Name and Address of Facility 27. Name and Address of Facility 28. Place of Destiny 29. Name and Address of Facility 30. Name of Address of Facility 31. Signature of Function Scott (Park) 32. Place of Destiny 32. Place of Destiny 33. Name of Address of Facility 34. Stock from Street, Elktron, MD 34. Stock from Street, Elktron, MD 34. Stock from Street, Elktron, MD 35. Sequentially list conditions, and street of the mode of dying, such as cardiac or respiratory errors. 10. Sequentially list conditions, and street of the Mode of Stock of Street and Address of Street Street (Park) 35. Sequentially list conditions, and street of Street Street (Park) 36. Due to (or es e consequence of): 36. Due to (or es e consequence of): 37. Sequentially list conditions, and street of Street Stree		17. Fether's Neme (First Middle I a		-						Maiden Sume	me)	
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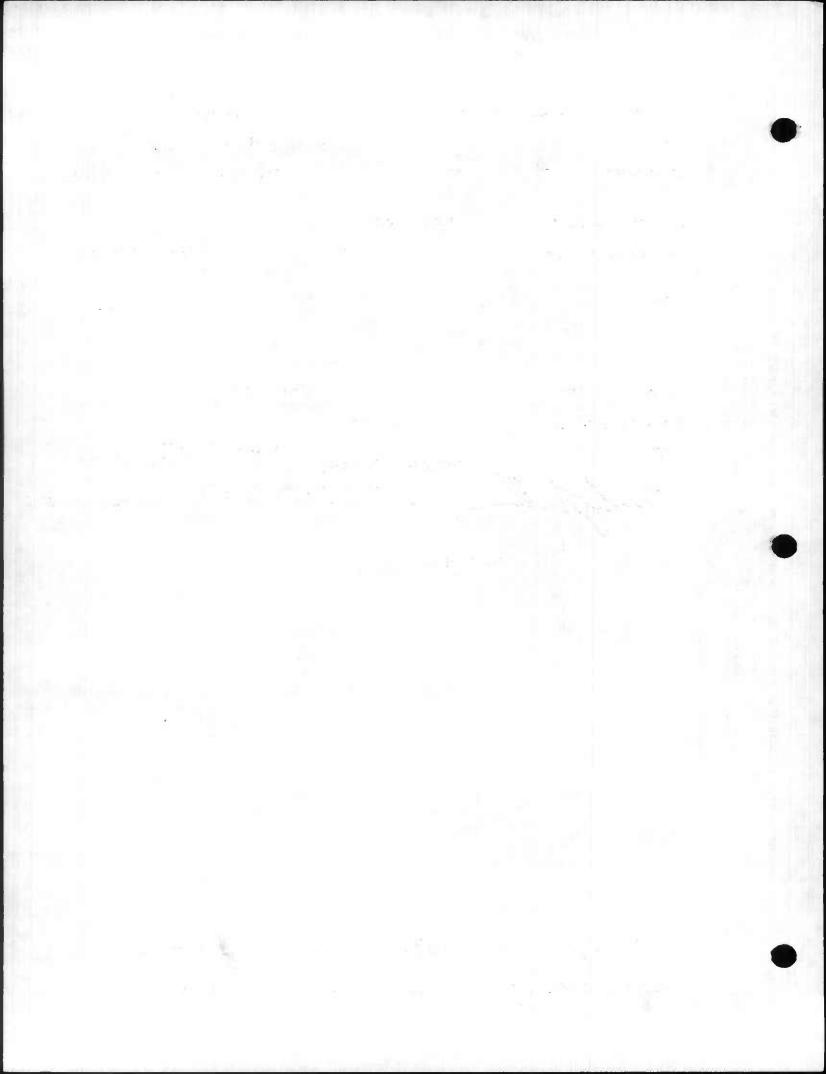
State of Maryland / Department of Health and Mental Hygiene 99 37704

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		KRISHAN MA	THUR, MD	., P.O	. BOX	1703,	LA P	LATA, MD	20646					
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State of Maryland / Department of Health and Mental Hygiene 99 37705

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Division	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Co	ould not be	206. Plac	e of Injury - At	home, fam	n, street, fac	tory, office			26f. Location	(Street	and Numb	er or Run	rel Route Number,
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		30. Name and address of per	son who d	completed cau	use of death (Ite	em 23a) (T	ype, Print)								
					D O		1700	т 2	DIZ	m »	MD 00	-			
	State	KRISHAN M 31. Data filed (Month, Day, Y			Regintrar's Sign	BOX	1,03	, LA		TA,	MD 20	1646			
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Amended #20 b (date), NLS,
11/10/00 Allegany Co. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37706 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Day 10:58 AM ALICE LEE DAUGHTREY November 16 /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner LIONS MANOR NURSING HOME CUMBERLAND ALLEGANY If Under 1 Year Months Days 5. Social Sacurity Number If Undar 24 Hrs. Hours Min. 8. Data of Birth Month Day, Yaar FEB. 19, 1905 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Hours 1 ☐ M 2 🛛 F WEST VIRGINIA 220-10-9382 94 Vrs Director Usual Rasidanca of Dacadant 10b. County 10a State 10c. City, Town or Location 10d. Insida City Limits must be notified at MD ALLEGANY CUMBERLAND 1X Yas 2 □ No Director 28a-f 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8 therms 23s 126 GREENE STREET 21502 U.S.A. Funeral 12. Was Decedant Evar in U,S.
Armed Forcas?
1 ☐ Yas 2 ☒ No
If Yas, Giva
Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Biack, Whita, atc 1 □ Navar Married 2 □ Marriad Maryland 21215-0020 "natural", or 1 ☐ Yas 2X No WHITE by 3 Widowed 4 □ Divorced Specify: Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry RETAIL CLOTHES Elamantary/Secondary (0-12) Collaga (1-4or 5+) store BUYER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) and Mental marked WILLIAM HEATH MARY RIGGLEMAN 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) . MARY SEIB/SOCIAL WORKER SETON DRIVE EXT., CUMBERLAND, MD 21502 important: If Isem 27 any injury or other to 20b. Place of Disposition (Nama of camatary, cramatory or othar placa)
SUNSET MEMORIAL PARK 20a. Mathod of Disposition 20c. Location - City or Town, Stata ъ 1 ⊠ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 11-19-99 CUMBERLAND MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition 3 weeks Examiner ue to (or as a consequence of). Examiner hysician end the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part L. Other significant conditions contributing to death both not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate hes been signed page 2 should be det Records, þ Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy alouna certificate 1 Yas 2 No 1 Yas 2 No of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 2 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) this lilled in by the funeral 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b Time of After 28c. Injury at Work? 28d. Dascribe how Injury occurred Division 5 Panding invastigation 1 X Natural s efter death. 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Hospital 24 hours 29a. Cartifian 12 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. Medical To the Hosp within 24 hou To the Funa completely fi (Check only one) 29b. Signature and title of Aertifier 29c. Licansa numbar 29d. Data signed (Month, Day, Year) November 16, 1999 19750 30. Nama and addrass of person who complated causa of de ath (Itam 23a) (Type, Print) Lions Maror N.H., Seton Drive Extended, Cumberland MD 21502 V. A. Ranjithan, M. D., 31. Data filed (Month, Day, Year) NOV 1 9 1999 nds 32. Segistrar's Signatura State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Des Month **Physician** AMELIA DIETZ MARTE NOVEMBER 13, 1999 7:45 P.M. · /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BERLIN NURSING & REHABILITATION CENTER BERLIN WORCESTER H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Days Months 1 M 2 XF 79 Director 219-05-0128 JUNE 23, 1920 MARYLAND Usual Residence of Deceden 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 1 Yes 2 No Director WORCESTER MARYLAND BERLIN 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 BURR HILL DRIVE 21811 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

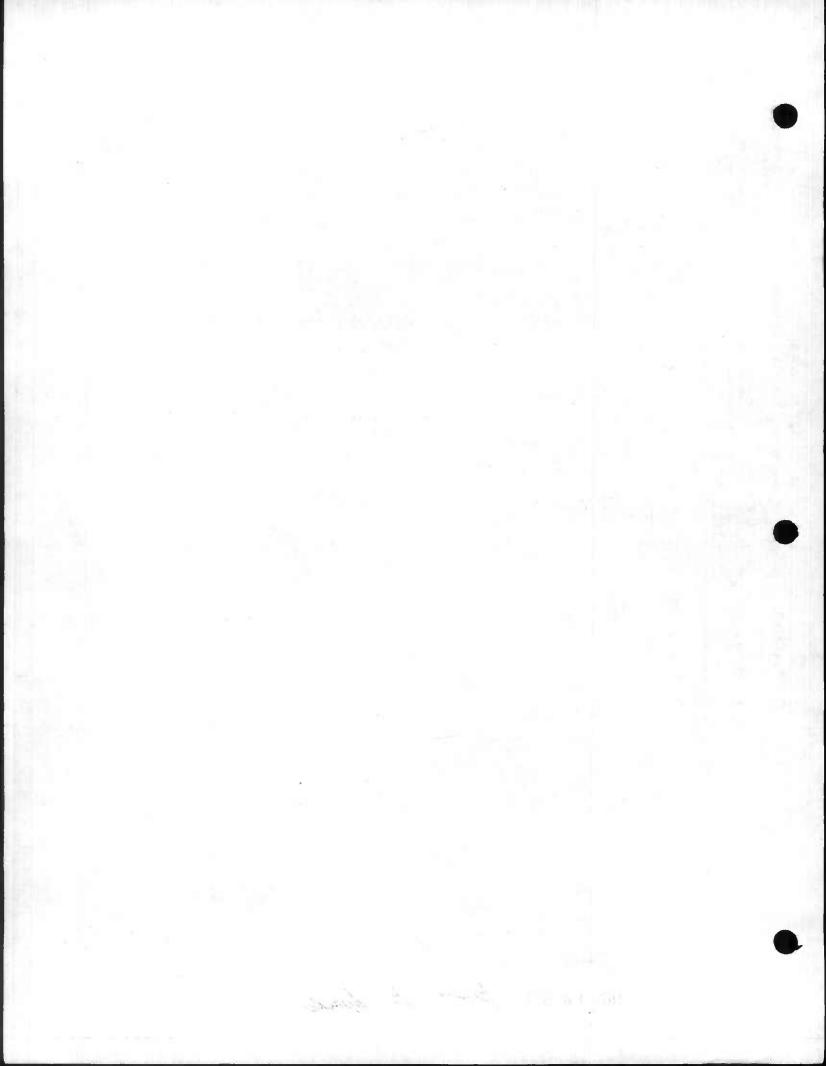
1 Yes 2 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Reca - American Indien. Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: þ WHITE 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t 6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN HOME HOMEMAKER Department of Health and Mental Hygie important: If fram 27 is marked other the eny injury or other traumatic event, the pace. 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be HARRY WERNSING MARIE HANLON 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) VERNON BECKER/SON 13 SASAFRASS, BERLIN, MARYLAND 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify) GLENWOOD CEMETERY 11/17/99 WASHINGTON, D.C. 21. Signeture of Euperal Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Tue and coursed the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, 23a. Pert1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner e mo chno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du - MISUlin Dep. DIAbe Fc, Due to (or es a consequence of): Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Jukgival Repan P 24b. Were eutopsy findings available prior to Completed 24e. Wes an autopsy completion of cause of death? 1 Yes 2X No t ☐ Yes 2 No 25. Was case referred to medical Be 26. Placa of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) 29b. Signeture and title of continue 29c. License number 29d. Date signed (Month, Dey, Year) 222 D02026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD. 410-641-4400 21811

State

Registrar

31. Dete filed a fonth Pay Year) 6 1999

32. Registrar's Signature



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BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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IMPORTANT: 1

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH JANET MARIE DOUGLASS November 17,1999 6:30 am M 4. SOCIAL RECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. April 20, 1953 266-11-5852 1 M 2 KK Tllinois 46 YRS 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2436 Frenchtown Road DIRECTOR Residence: Port Deposit Harford RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Cecil Port Deposit 1 TES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2436 Frenchtown Road 21904 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married Swedish BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'B EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Aberdeen Proving Ground Elementary/Secondary (0-12) College (1-4 or 5+) Two Years Court Reporter Aberdeen, Waryland 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surneme) Olaf Harald Johanson Bertha Nilson BE 19e. INFORMANT'B NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jones All Douglass, II (Husband) 2436 Frenchtown Road, Port Deposit, Maryland 21904 20a. METHOD OF DISPOSITION
1 □ Burlet 2 Å Cremetton 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Ferris & Co., Inc. 11/18/99 West Chester, Pennsylvania 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville. Maryland 21903-0188 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such sa cardiac or respiratory strest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death METASTASTE disease or condition_ EARS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAR ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 WES 2 NO 1 YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN IN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 PHO 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 - Nursing Nome 5 Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, Ierm, street, lactory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) a Could not be 4 Homicide 29e. CERTIFIER 1 DCERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. e basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMIN 286. STONATURE AND TITLE OF CERTIFIES

31. DATE-FILED (Month, Day, Year)

M. J

32. REGISTRAR'S SIGNATURE

10. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

19c. LICENSE NUMBER

DHMH-16 Rev 1/89

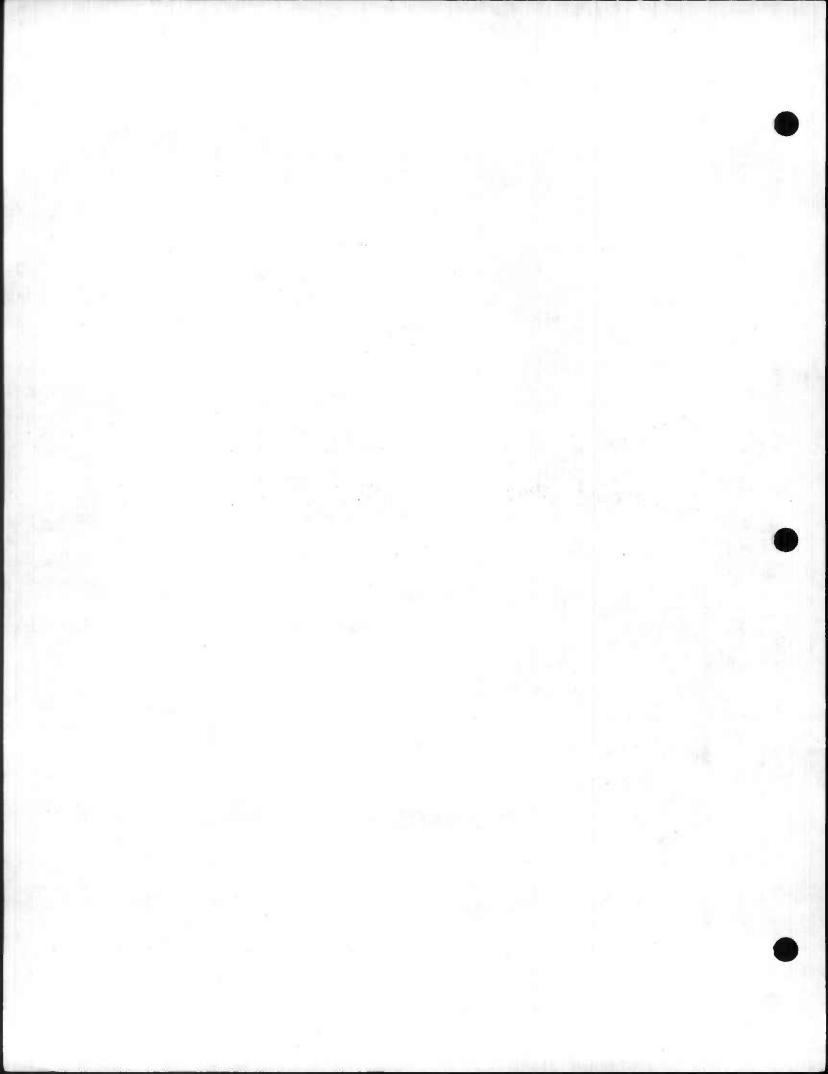
29d. DATE SIGNED (Month, Day, Year)

> NOVEMBER

Sastway

State of Maryland / Department of Health and Mental Hygiene 99 37709

				Certificate	e of	Death		R	eg. No.	U	1105
Physician /Medical	Decedent's Neme (First, Middle, Las Eleanor	Romain	e	Feaga		1		2. Date of Deal Month November:		Year	3. Time of Deeth 8:11 AM
Examiner	4a Facility Neme (If not institution, give 904 Pine Avenu					4b. City, To Fred			Frede:		
Funeral Director	5. Social Security Number 6. St 220-01-1283 1 Usual Residence of Decedent	9x 7. Age ☐ M 2XF	(In yrs. last birtl 79 Y	mday) If Under Months	1 Year Deys		24 Hrs. Min.	8. Dete of Birth (Month, Day, Nov • 1	Year) 4, 1920	9. Birthp Coun Mar	laca (State or Foreign try) Tyland
death with the Maryland me 23e or 28e-f show constitute motified at neral Director	10a. Stete 10b. County Maryland Freder:		10c. City, Town Freder:							11	0d. Inside City Limits 1 Yes 2 □ No
O iffer death with the Ma r forms 23s or 23s-fs inner must be notified furneral Director	10e. Street and Number 902 Pine Avenue	е		10f. Zip 21	701			1	U.S.A.		try?
To the Part of	11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates;		13. Was Deced If Yes, spec	ify Cub	an, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		k, White, (
	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+		Decedent's Usue 'Give kind of wor life. DO NOT us ecretar	k done e retire	pation during mos d)	t of worki	ing	16b. Kind of Bu		
C A Part O	17. Fether's Neme (First, Middle, Last)					18 Mothe	r's Neme	(First, Middle, I			
d be fill the cod out of the cod out	Burley		S	mith			stel			Humi	mer
Maryland d2 should be file th and Mental Hy 77 is marked othe Traumatic event To Be C	19a. Informant's Neme/Reletionship (7 Mr. Darryl L. Fea		19b.	Mailing Address 5 Pontia		t and Numbe	er or Rura	al Route Number			
Baltimore, Maryiand 212: permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hyglena. Important: If item 27 is marked other than eny injury or other traumatic event, tha Medica. To Be Compi	20a. Mathod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from Stete	20b. Place of	Disposition (Nem crematory or of t Hill Cer	e of	ice)		Date	20c. Location ·	City or To	
Balti Permit. Depertmine on injury	21. Signature of Funeral Service Licen	MAIL	0255		and	d Basi	ford	P.A. Fu			1701
Physician //	23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only of	olicetions to et caused to one cause en each line	he death. Do no	ot enter the mode	of dyi	ng, such es	cardiac d	or respiretory err	est,	1	Approximate Interval Between Onset end Deeth
Examiner	Immediate Cause (Finel disease or condition resulting in death)			onsequence of):	_	+	,		-		lohrs.
BOX 58/50, ath certificate be executed thending physician and for use as the burist-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. 13	ue to (or as a co	onsequence of):	ردا	lita)			12	Lo year)
death death of for u	Part II. Other significant conditions co	atributing to death but	not resulting in	the underlying or	uso di	ven in Part I		23h Did to	phaceo use con	tribute to	the cause of death?
Phy Helph	Cerchrova	1	ردو، ل	nt disconying d	iuse gr	VOIT III F GILL		1 U Y			bably 4 Unknown
aw requires to the second of t	Carcinam	a of b	realt	_	4			24a. Wes a perform		ava	ere eutopsy findings ailable prior to mpletion of cause death?
= - 40	Hyperte	nsim						1 🗆 Y	es 2000	10	Yes 2 No
Or VItal Physicien: T this cartificat rai director, pc	25. Wes case referred to medical exeminer?	Hospital:	-0		. Ot	han		(Check only or			. Neighbor's
O £ 5 7	27. Manner of Death 1 Natural 5 Pending	28a. Dete of Injury (Month, Day	28b. Ti		Bc. Inju Wo	iry at ork?		me 5 Reside 28d. Describe h			House
DIVISION OF To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, fari (Specify)	m, street, factory		Yes 2 -		28f. Location (S City or Town	treet and Number n, State)	er or Rura	il Route Number,
To the Hospital or within 24 hours afte to the Funeral Dir complately filled in Medical Cert	29a. Certifier (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of e and manner stets	xaminetion and	death occurred a for investigation,	it the ti in my o	me, date an opinion, dea	d place, a	and due to the c	ause(s) and ma ate and plece, a	nner as si and due lo	tated. the cause(s)
To the within To the comp	29b. Signature and title of certifier	races)	F 1			se number 9689			9d. Date signed November		
	30. Name and address of person who of A. Austin Pears				int	h Stre	eet,	Frederi	ck, Mar	ylan	d 21701
State	31. Date filed (Month, Day, Year)	32. Registra	Signeture	. 4		,					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Justine Cecelia Free1and 17, November 1999 4:45 P.M. 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dev. NOV. 16 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Year 1999 Days Hours 1□M 2☑F Frederick MD none Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Frederick Frederick 10g. Citizen of What Country? 10e. Streat and Number 10f Zio Code 9125 Ridgefield Lane 21701 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuef Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Edward Freeland Linda L. Pace 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9125 Ridgefield Lane, Frederick, MD John Edward Freeland/father 21701 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Surial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Peter & Paul Cem. 11/24/99 Springfield, PA 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signeture of Funeral Service Licenses algun 1621 Opossumtown Pike, Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, abock, or heart feilure. List only one cause on each line. Approximete Intervel Setween Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) CARDIAC ARREST Due to (or as e consequence of): , SUSPECTED MYOCARDITIS AND PNEUMONITIS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or es a consequence of) SUSPECTED CONGOVITAL INFECTION Due to (or es a consequence of):

Physician /Medical Examiner physician and the burial-transit The law requires that the deeth certificate be executed

Records, P.O. Box 68760.

Division of Vitai I or Attending Physician:

Affer death.

24 hours after deal Funeral Director: filled in by

To the Hosp within 24 ho. To the Fune completely fi

Hospitai

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

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Completed

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MD

with the Maryland

death v

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental hygiene.

Important: If item 27 is marked other than any injury or other traumany.

Examiner Physician/Medical þ Completed Be 2

Certification:

edical

29b. Signeture end title of certifier

		ontributing to death but not rec					ontribute to the cause of death? 3 Probably 4 Unknow
						24e. Wes en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
25. Was case referred	to medicaf				26. Place of D	seth (Check only one)	
exeminer?		Hospitel: 1 Hapatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Of	ther (Specify)
2 Accident	5 Pending investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of finjury	M 280	Nork? NA Work? NA 1 Yes 2 No	28d. Describe how injury occu	irred
3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, atreet,	, factory,	office	28f. Location (Street end Num City or Town, Stete)	ber or Rurel Route Number,
						ce, and due to the cause(s) end no curred et the time, date end place	

29c. License number

State Registrar

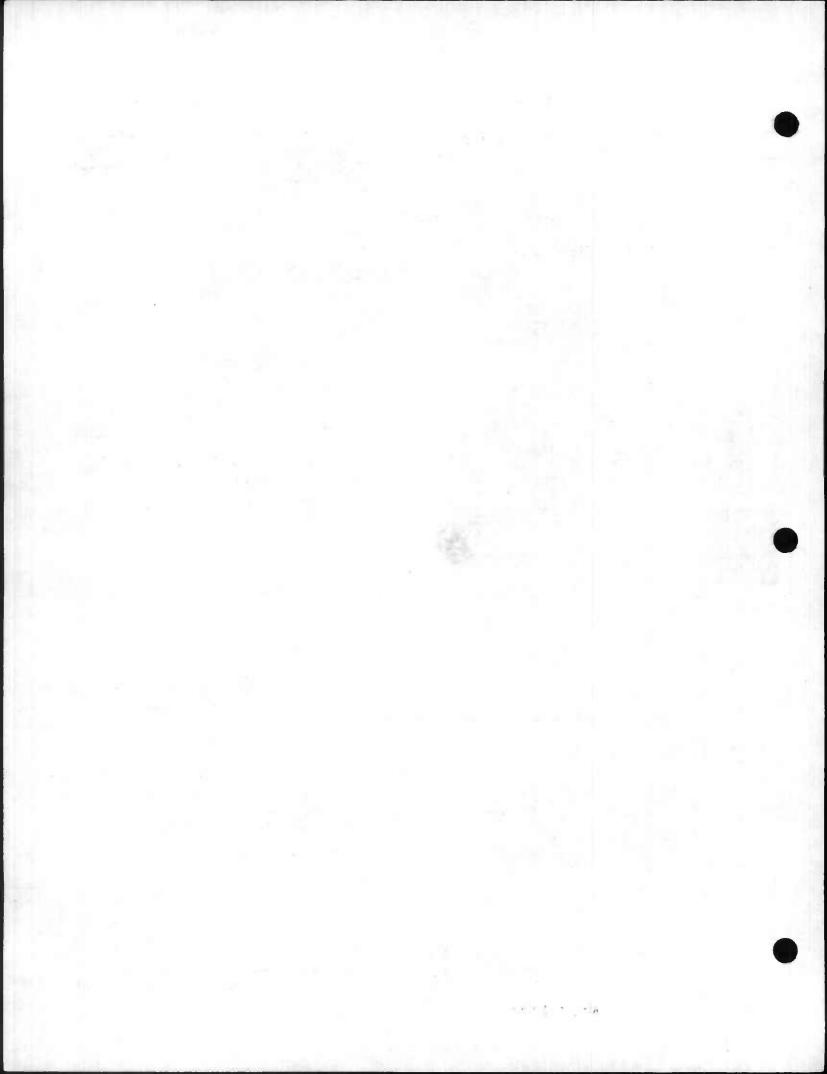
32. Registrat Signature 31. Dete filed (Month, Dey, Year) 1999

30. Name and address of person who completed cause of deeth (fight 23a) (Type, Print) FRD 221CK MEMORIAL CHRISTOPHER & HULTZEN, ND 400 W, 7PJ STREET, FD HOSPITAL FREDERICK ND

30/00

29d. Date signed (Month, Dey, Year)

NOVEMBER 17, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Ocillee Bounder Wovembl 14 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO H Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 224-14-8726 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Virginia Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location (hinco teague 1X Yes 2 No Virginia Accomack 10e. Street and Number 10g. Citizen of What Country? 6158 Maddox Blvd. U. S. A. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Status Black, White, etc. 1 ☐ Yes 22 No If Yes, Give Year or Detes: 1 Never Married 2 Merried White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working plife. DO NQT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Self Homemaker 17. Father's Neme (Eirst, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City of Town, State, Zip Code), 6158 Maddox Blvd. (rinco teague, Virginia 23336 Oscar W. Fox, Sr. Husband 20b. Plece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State metory or other place) 1 Burlal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11-17-99 Temperanceville, John Taylor (emetery 21. Signeture of Funeral Service Licenses 23 Name and Address of Eacility Home (hinco teague, Virginia 23336 23a. Part1. Enter the disease, or complications that caused the deeth Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediete Ceuse (Final CABPION YOPATH Due to (or as a consequence of): disease or condition resulting in death) CITEMIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 45CVD Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Funeral

Director

288-1

Hygiene. other than "natural", or lisena 23a or

Pages 1 and 2 should be nent of Health and Mental

is marked

mportant: If Item 27

Department of

Maryland 21215-0020

Physician/Medical Examiner þ Be Completed Certification: To

Records, this certificate of Vital I or Attending Physician; after death.

Director: After this certifica director, Division within 24 hours a To the Funeral D completely filled Hospital

25. Was case referred to medical examiner? 1 ☐ Yes 250No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

3 Suicide 4 I Homleide 29a. Certifier

281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifier

1 Propertifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chodnicki M. J.

SALISBUMI EASTERN 400 mo

State Registrar

Medicai

3

31. Date filed (Month, Day, Year) NOV 1 6 1999

32. Registrar's Signature

To the

Study of Louis .

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) **Physician** EDWARD JOSEPH FUNK /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number) Examiner CIVISTA MEDICAL CENTER LAPLATA 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Yaar **Funeral** Days Months 1 XM 2 ☐ F Director 578-22-7326 Usual Rasidance of Dacedan death with the Maryland 10a Stata 10b. County 10c. City. Town or Location Show mast be notified at Director MD Charles La Plata 10e. Street and Number 10f. Zip Coda

If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Yaar) 9. Birthplaca (Stata or Proceign 10,1926 Washington 10d. Insida City Limits 1 X Yas 2 □ No

Reg. No.

21

2. Data of Daath

Month NOV

128 Wood Duck Circle 12. Was Dacedant Evar in U,S. Armad Forcas? 11 Marital Status

20646 13. Was Decadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 🏖 ☐ No Specify:

14. Race - Amarican Indian, Black, Whita, etc. Specify: White

3. Tima of Daath

5:30 A.M

15. Decedant's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12)

1 Nevar Marriad 2 Marriad

3 Widowed 4 Divorced

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Printer

Federal Govt.

16b. Kind of Businass/Industry

1999

4c. County of Death

CHARLES

10g, Citizan of What Country?

USA

17. Fethar's Neme (First, Middle, Lest) Joseph Funk

Funerai

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Completed

Be

if of Health and Mental Hygiene.
If them 27 is marked other than "natural", or items or other traumatic event, the Medical Examines or other traumatic event, the Medical Examines or

Department of Important: If any Injury or pince.

Physician /Medical

Examiner

buriel-transit

the

USB 85

ed by the a deteched f

signed b

page 2 should Completed

director.

funeral

in by the

certificate

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica

24 hours

To the Hosp within 24 hou To the Fune completely fi

Bud

physician

requires that the death certificate be exec

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medicai

by

Be

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Certification:

edicai

Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

altimore, Maryland 21215-0020

Eunice Clark

19a. Informant's Name/Relationship (Type, Print)

19b. Meiling Address (Straet and Numbar or Rural Routa Number, City or Town, Stete, Zip Code) 128 Wood Duck Cir. La Plata, MD 20646

18. Mother's Name (First, Middla, Maldan Sumema)

Patricia Funk/Wife 20a Mathod of Disposition Burlal 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify)

20b. Place of Disposition (Nama of cematery, crematory or other place)

Date 20c. Location - City or Town, State

21. Signatum of Funaral Sarvice Licensaa

Yas 20 No

Collega (1-4or 5+)

Yaar or Datas:

Trinity Memorial Gar, 11/24/99 Waldorf, MD AREHART-ECHOLS FUNERAL HOME, P.A.

6

P.O. BOX 567 LA PLATA, MD 20646 M00945 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximata Interval Batween Onsat and Daath

Immediate Ceuse (Final disaasa or condition

LYMPHOMA

Due to (or as e consequence of):

PNEUMONIA

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Ceusa (Diseasa or Injury that initiated avents rasulting in daath) Last

Dua to (or as a consequence of):

rt II. Other significant	conditions contributing	g to death but not ras	ulting in the underlying	causa givan In Part

23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Wera autopsy findings availabla prior to complation of causa of daath?

2 No 1 Yas

1 ☐ Yas 2 ☐ No

25. Wes cesa rafarrad to madical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA

1 Yas 2 No 27. Menner of Daath 28e. Data of Injury (Month, Dey Year) 5 Panding invastigation 1 Natural 2 Accidant

6 Could not ba detarmined

28c. Injury at Work? 28b. Time of 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28e. Plece of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

Location (Straet and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

3 Suicida

4 \(\text{Homicide} \)

🌠 Certifying Physician: To the best of my knowladga, daath occurred at tha time, deta and piece, and dua to tha cause(s) and mennar as stated. 2 Medical Examiner: On the basis of exeminetion end/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated.

29b. Signatura and titla of certifiar

29c. Licansa number D-054804

29d. Data signed (Month, Day, Year)

Khair Fox

99

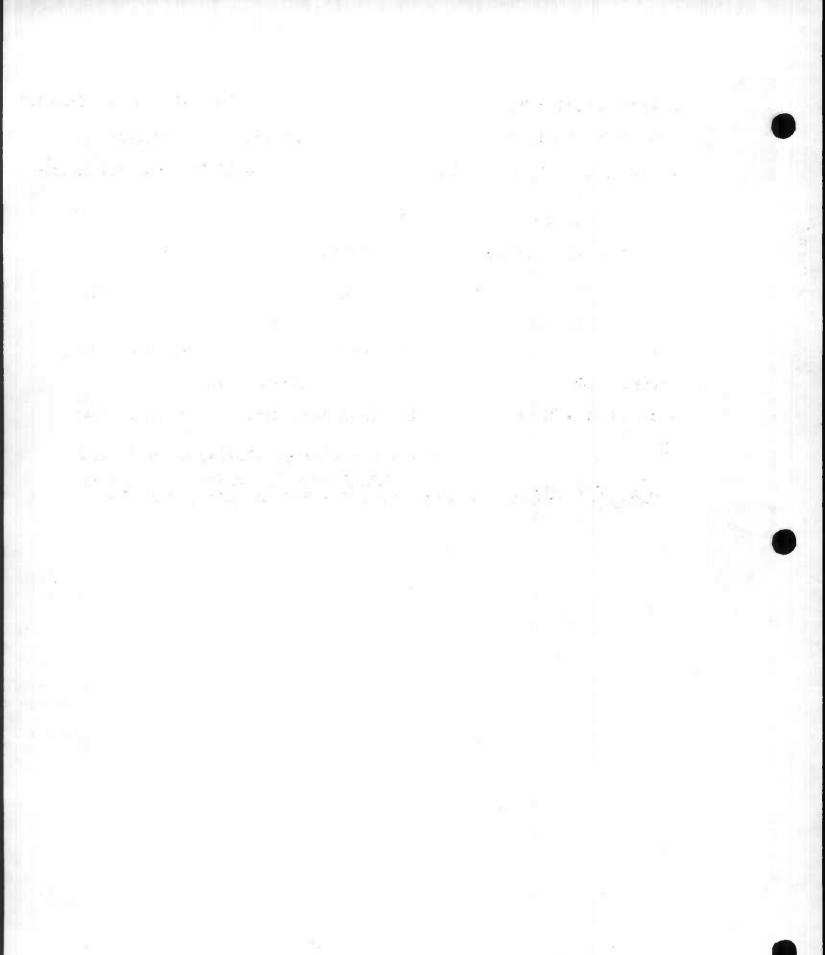
30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Print)

CENNA MEDICAL CENTER 7C POST OFFICE RD, WALDORF, MD 20602 KEVIN LEE MD 31. Deta filed (Month, Day, Yaar) NOV 22 32. Registrer's Signatura

State Registra

DHMH 16 Ray 6/95

Docks



State of Maryland / Department of Health and Mental Hygiene 99 37713

				Certificate of	Death	Re	g. No.	-	0///0.
			Decedent's Name (First, Middle, Last)			2. Dete of Deeth	h		3. Time of Deeth
н	Physic		Vathern Anna Cu			Month	Dey	Year	
Я	_/Medi		Kathryn Anna Gr 4e. Fecility Neme (If not institution, give street and number)	imes	4h City Town or	November Location of Deeth		1999	2:45 PM
и	Exami	ner	46. I desirty Name (if not institution, give street and number)		40. City, Town, or	Location of Deetin	4c. County	of Deeth	
Ш	18		5. Social Security Number National Lutheran Home		Rocl	kville		Mont	gomery
	ر Funeral		1 DM 2 DE	Months Devs			Yeer)	9. Birthp	gomery lace (State or Foreign http)
4	Director		220-52-7682	Yrs.		January 1			est Virginia
	D.		Usuel Residence of Decedent			Julium y = 1	0, 1710		voc vingima
	how	L	10e. Stete 10b. County 10c. City,	Town or Location				14	0d. Inside City Limits
	A T	to	Virginia Fairfax		Reston				1 ☐ Yes 2 ☐ No
	1 the	Director	10e. Street end Number	10f. Zip Code	Kesion	10	og. Citizen of V	Whet Coun	itry?
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	eath	era	2231 Colts Neck RD Apt, #321	12 Mas Decedent of	22091	Specific Manage No.	14 Dec	US	
	72 hours after death with the Maryland naturel', or terns 23a or 28a-f show dred Examiner must be notified at	Funeral	Armed Forces?		ben, Mexican, Puer	rto Rican, etc.)		e - America ck, White, e	
20	s af	by F	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No	Specify:		Specify	<i>i</i> :	
8	hour	Q P	3 Widowed 4 □ Divorced Year or Dates:						White
21215-0020	hin 72 hours s. in "naturel", Medical Ex	Completed	15. Decedent's Education (Specify only highest grede completed)	16e. Decedent's Usual Occu (Give kind of work done	e during most of wo	orking 1	16b. Kind of Bu	usiness/Ind	fustry
2	2 . 0 3	du	Elementery/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retire	9d)				
	filed witl Hygiene ther the	Ö	12	Ho	memaker			Own I	-lome
pu		Be	17. Fether's Name (First, Middle, Lest)		18. Mother's Ne	me (First, Middle, M	laiden Sumem	10)	
Maryland		T _o	Frank Weber			Loui	se (Qua	ntz)	
any	d 2 should the end Men 7 is marked traumatic		19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Stree	et end Number or F				Code)
Ξ	475 d		Norma G. Meyer						
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Baltimore,	00		1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State	netery, cremetory or other ple	ece)		oo. Location -	Ony or 10	WII, Oldle
Ë	Part tant			kes Cemetery		11/24/99	Cur	mberla	and, MD
a	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensise	22. Name end Addre				~	
ш	20799		h). ((), 200	Kight Fi	uneral Hor	ne 309-311	Decatu	r St.,	
			23a. Pert1. Enter the disease, or complications that caused the deeth. shock, or heart feilure. List only one cause on each line.	Do not enter the mode of dy	land MD	21502 c or respiratory erre	st.		Approximete
	Physician	i n	shock, or heart feilure. List only one cause on each line.						Intervel Between Onset end Deeth
}	/Medical		Immediate Cause (Final					4	
	Examiner		disease or condition resulting In deeth) e.	na					48 hours
		70	Due to (or e	es e consequence of):		0 0	,	, ,	7 nuleus
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	and tran	Examine	Sequentielly list conditions, Due to (or e	es e consequence of):					
Ő,	e ex	m	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Vila Me	1/1/11	Tulo	77	1	50 1. 2 22.
68760,	entificate be executed ding physician and se es the buriel-transit	/Medical	that interest of injury thet initiated events Due to (or e	se e consequence of): Levis e consequence of): Levis e consequence of):	neur	Type.	//		so year
	g ph es ti	P	resulting in deeth) Last						
XO	odin Ise		d						
\mathbf{m}	that the deeth of the attention of deteched for un	Physician	B 11 01 1 11						
О	the d y the	ys	Pert II. Other significant conditions contributing to death but not resulting	ng in the underlying cause gi	ven in Pert I.	23b. Did tob	IACCO USS CON	ntributs to	the causs of death?
	The law requires that the ate hes been signed by th page 2 should be detech	4	Alshermer's Hementer. He	sher Coners	6	1 🗆 Ye	8 2 No	3 Prob	bably 4 Unknown
Division of Vital Records,	signed of be de	by	Hyps Hyrrelyn,	The contract	-/				
5	v require	Completed	Huba Unoral and	,		24a. Wes en		eve	ere autopsy findings elleble prior to
Ö	aw r	De la	the officers of					of c	npletion of cause deeth?
ď	The lav ate hes page 2	E				1 □ Yes	s 2.2No	15	Yes 2□ No
a			25. Wes case referred to medical) 162 5 140
>	ysician: is certific director,	o Be	exeminer?	Or	her:	eth (Check only one			
o	Attending Physician: or deeth. actor: After this certific by the funeral director,		1 Inpatient 2 EF	Voutpetient 3L DOA	4 Nursing F	Home 5 Residen			')
Ë	ding h. After funer	ertification:	Neturel 5 Pending (Month, Dey Year)	8b. Time of lnjury 28c. Inju		28d. Describe how	v injury occurr	ed	
S	after deeth Director: A in by the f	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1]Yes 2□No				
2	after deet Director:	=	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home building, etc. (Specify)	e, ferm, street, factory, office		28f. Location (Stre City or Town,		er or Rural	Route Number,
	is af	Cer							
	hou hou in it if		29a. Certifier 1 Cartifying Phyalcian: To the best of my knowle	dge, deeth occurred et the ti	me, dete end plece	e, end due to the cau	use(s) end ma	nner as ste	eted.
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical	(Check only one) 2 Msdical Examiner: On the basis of examinetion end menner steted.	end/or Investigetion, In my o	opinion, deeth occu	urred et the time, det	e end plece, a	and due to	the cause(s)
	Nithii To th	×	29b. Signature and title of certifier	29c, Licens	se number	29	d. Date signed	d (Month, E	Dey, Yeer)
	رځ		101 - 200	1 172	1/15	-			
	3	1	Swenn Mil	v. 10)	6610	N	ovemle	22	1,1777
	no	s	30. Neme and eddress of person who completed cause of deeth (Item 2:						
	1000			1 Veirs Drive	, Rockvi	Lie, MD 20	1850		
	Sta	te	31. Dete filed (Month, Day, Yeer) 32. Fegistrer's Signetur	B 4 1-	1				

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State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death		Reg. No.	9 3	1114
	Division in		1. Decedent's Name (First, Middle, Last)				100		2. Dete of D Month	eath Day	Year	3. Time of Death
k	Physicia /Medic	_	CHARLES RU	SSELL	GEA	RING	ER		Novemb		1999	1:32 PM
	Examine	_	4a Facility Name (If not institution, give stre	et and number)				4b. City, Town,	or Location of Dea		y of Deeth	
			Frederick Memorial	Hospital				Freder		Fr	ederi	ck
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir		If Under 1 Year Months Days		Hrs. 8. Date of B. (Month, D.	irth ay, Year)	9. Birthpl	ace (State or Foreign
	Director		217-16-2793	21.7	75	Yrs.				9, 1924	Mary	
	pu *	1	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town	n or Loca	ation	_			10	Od. Inside City Limits
	lenyti aho	5									"	1 X Yes 2 No
	r 28s-f ahow	Director	Maryland Frederick 10e. Street and Number		Frede	rick	10f. Zip Code			10g. Citizen of	What Count	10/2
	23a or		200 Norva Avenue					1				.,,,
	72 hours efter deeth with the Meryland natural, or items 23s or 28s-f show neal Examiner must be notified at	Funeral		Was Decedent Ev	er in IJS	13 W	2170		? (Specify Yes or N		ce - America	an Indien
	her dee	5	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No		HY	Yes, specify Cut	an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	Bla	ack, White, e	
320	Ir, or	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: W	WIT	10	☐Yes 2][No	Specify:		Specia	y: Whi	te
21215-0020	72 hours natural',	9	15. Decedent's Educati	on		. Decede	nt's Usual Occu	pation		16b. Kind of E		
215	within 7. ene. than "ry	Completed	(Specify only highest grade co	ompleted) College (1-4or 5+)		(Give ki	ind of work done O NOT use retire	during most of d)	working			
2	d withingiene.	E	12	Oollege (1 401 51)		Chi	ef Acco	untant		Potom	ac Ed:	ison
pu		Be	17. Father's Neme (First, Middle, Last)					18. Mother's	Name (First, Middle	e, Maiden Sume	me)	
Vla	Ment Ment Ment Ment Ment Ment Ment Ment	9	Edward Russell Gear:	inger				Edith	Burrier			
Maryland	and and		19e. Informant's Name/Relationship (Type,						r Rural Route Num			
-	and alth		Laura J. Mohr (Daug	ghter)				7, Harp	ers Ferry	, West	Virgi	nia 25425
ore	f of He or oth		20a. Method of Disposition 1√□ Burlel 2 □ Cremation 3 □ Rem	ovel from State	20b. Place of cemeter	f Disposit ry, creme	tion (Name of story or other pla	ice)	Date	20c. Location	- City or To	wn, State
Ë	Pa Hart:		4 □ Donetion _5 □ Other (Special	Over Holli Otale	Restha	ven	Mem. Ga	rdens	11/20/99	Freder	ick, I	Maryland
Baltimore	Departr Departr Importu any Init		21. Signature of Function Service (confine	100	-/	ROP	Name and Addr	DATLEY	& SON FUI	JERAI HO	MES	РΛ
m	89589		Sofeth	talley	SY				ST., FRI			
			23a. Pert1. Enter the disease, or complicate shock, or heart failure. List only one of	ions trust caused th	e dath. Do							Approximete Interval Between
	Physician		shook, of hour failure. Elst only one	ouse on each line.	. 0						1	Onset and Deeth
	/Medical		Immediate Cause (Final disease or condition		16	PSL	2					hrs
В	Examiner		resulting In deeth) a	Du	ie to (or as a	conseque	ence of):					0
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	icate be asscuted physician and s the burial-transit	Xar	Sequentially list conditions, if any, leading to immediate	Du	e to (or as e	conseque	ence of):			. 1		0.
60	De a		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		U	NIVI	ARY THE	ACT &	nonume	MICOLIN	1	ours
68760,	tificate be axecul g physician and as the burial-trar	edicai	resulting in death) Last	Du	e to (or as a			11.			i .	
-	E 0 6	-	d		0	1000	wonve	rob	MILIN			werks
Box	the death ce y the ettendii sched for use	Physician/N						1	0			
o.	the d	ysi	Part II. Other aignificant conditiona contrib	uting to death but i	not resulting in	n the und	lerlying cause gi	ven in Part I.				the cause of death?
0	that the dete	4	IZEMAL THIS	Mun	1				1	Yas 20 No	3 Prob	bably 4 Unknow
Vital Records,	8 53	d by	3.1		10	1	0 1 .		24a We	s an autopsy	24b. We	ere autopsy findings
00	per v	ete	MCONACTURIO	m sp.	Meec	nul.	of blo	iddle_		formed?	con	ailable prior to appletion of cause
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B	ficate or, pa		OF Mine case returned to medical						11/2	Yes 2□No	1	Yes 212 No
5	Physician: The lew rhis certificate has beral director, page 2 s	200	25. Wes case reterred to medicat examiner? 1 Yes 2 No Hos	oitel:	• C 5010		- Ot	hor	Deeth (Check only			
ō	Physical distriction	2		12 tnpatient 28a. Dete of Injury	1	Time of	3LI DOA	4 LI NUISII	ng Home 5 Res	how injury occu		9
O	ding in.	Tio	1 Retural 5 Pending 2 Accident investigation	(Month, Day Y		Injury	28c. Inju Wo	rk?]Yes 2∐No				
Division	Attending ir deeth. ector: Afte by the fune	1ca	3 Suicide 6 Could not be	28e. Place of Injury	- At home, fe	rm, stree	et, tactory, office		28f. Location	(Street and Num	ber or Rura	l Route Number,
á	afte Dir	Certification:	4 Homicide	building, etc. (Specify)				City or To	own, State)		
		edical C	29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner:	an: To the best of r On the basis of ex	camination and	e, death o	occurred at the ti stigation, in my	me, date and p opinion, death o	lace, and due to the	e cause(s) end π , date and place	nenner as st	ated. the cause(s)
	ithin of the sample	Ž	29b. Signature end title of certifier	ora merarer steller	·		29c. Licen	se number		29d. Dete sign	ed (Month. I	Day, Year)
	o T × T o		1 Muckel	/				19591		11/171	100	
		-						1 1 71		11/1/	11	
			30. Name and address of person who comp					D. 1 .	.1	1 01-	0.0	
			Mark P. Rubin, MD 31. Date tiled (Month, Day, Year)	32 Bacietre	Signature	ison	Drive,	rrederi	ck, Mary	Land 21/	02	
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DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** William 6:35 PM Gernert 11 9 99 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Marghand Medical System Ba Homere University If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 MM 2□ F Yrs. 216-44-7861 Director 55 Jan. 19, 1944 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Grasonville Queen Anne's 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 208 Church Lane 21638 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indian, Bieck, White, etc. hours after 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: if flem 27 is marked other than any injury or other traumatic event, the page. 12 MTA Police Officer Police 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Christian Gernert Jr. Lillian Grace Collins 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Beverly Gernert 208 Church Lane, Grasonville, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 Easton, MD Nov. 13, Woodlawn Memorial Park 21. Signety 22. Name end Address of Fecility of Funarei Sa wice Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619 23a. Pert1. Enter the disease or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or haert failure. List only one cause of aach line. Approximete Interval Between Onset and Deeth **Physician** Immediate Causa (Final disease or condition rasulting in death) /Medical Biventricular how Examiner Physician/Medical Examiner Correnary sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) attending physician Box 68760 the Due to (or es a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, ρ 24b. Wara autopsy findings available prior to Be Completed 24a. Was en autopsy Hyper hpidemis completion of cause of death? 1 Yes 2 000 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Netural 5 Panding investigation after death. 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifian 1 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data end place, and dua to tha cause(s) and manner as stated. Corrupting Physician: 10 that best of my knowledge, death occurred at that time, data only pace, and do to the cause(s) and manner. On the basis of examinetion and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) and manner steted.

State Registrar 29b. Signature and title of certifie

South

31. Date filed (Month 19) (ear) 2

30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print)

1999

ancen

Street

To the

- Bultimore

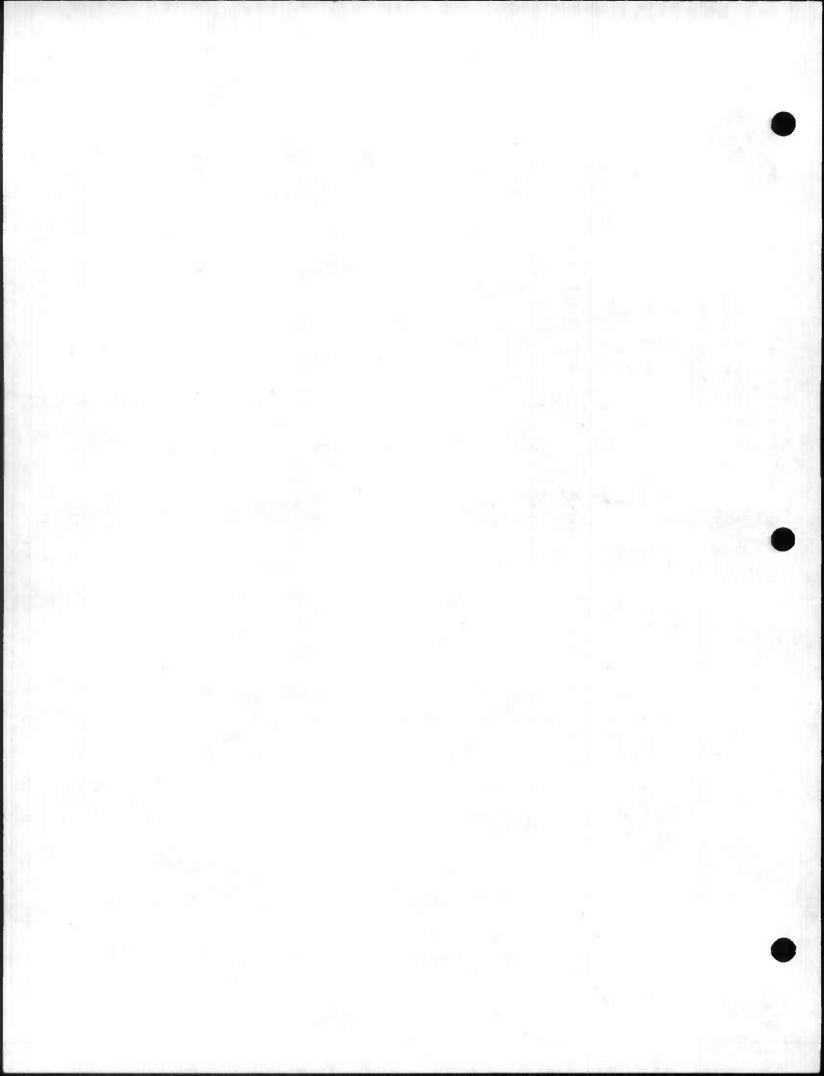
32. Register's Signeture

29c. License number

2120

29d. Date signed (Month, Day, Year)

Charles S. D



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 18, Frances Gawronski November 1999 1:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Laurelwood Care Center Elkton Cecil 8. Dete of Birth (Month, Day, Year) 1an. 15, 1 If Under 24 Hrs 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F 221-16-9290 73 1926 Delaware Director Usual Residence of Decedent the Mandend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Cecil Chesapeake City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Holly Beach Rd. 21915 USA deeth v 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indien. Bleck, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygland Important: if Item 27 is merked other tha eny Injury or other traumatic evant, that page. 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 0 Aubrey H. Hughes Anna Filkins 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Bach/Daughter PO Box 49 Chesapeake City, MD 21915 20b. Place of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gracelawn Memorial Park 111-23-99 Wilmington, Delaware R. T. Foard Funeral Home, P. A. 21. Signature of Funeral Service Licenses 318 George Street Chesapeake
or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. Chesapeake City, MD 21915 Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Fine) latou disease or condition resulting in death) Examiner Examiner physicien end s the burlai-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cont Box 68760 Physician/Medical Due to (or as a consequence of): for use es 8 885 P.O. ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 400 Propage sixue disorder Division of Vitai Records. à 24b. Wera autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 1 Yea 20€No 1 Yes 2 No Attending Physician: director. 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deet To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ò Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. To the I within 2. 29b. Signatupipand title of certified 29c. License number 29d. Date signed (Month, Day, Year) alleda 1254 16 pleted cause of death (Item 23a) (Type, Print) ne and address of person wh Parey, MD Barbara A. 111 W. High St., Elkton, MD 21921

DHMH 16 Rev 6/95

State Registrar 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Physician Hammond Harry Martin Nov. 25 1999 1110 /Medical 4c. County of Death 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Memorial Hospital Easton Talbot 5. Social Security Number 214-10-4746 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country) Va. **Funeral** Days Hours Months Min. Director Usual Residence of Decedent 10a Stete 10b. County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Caroline Denton Maryland Directo 238-7 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 24879 Woods Drive 21629 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours sher ment of Health and Mental Hygiene.

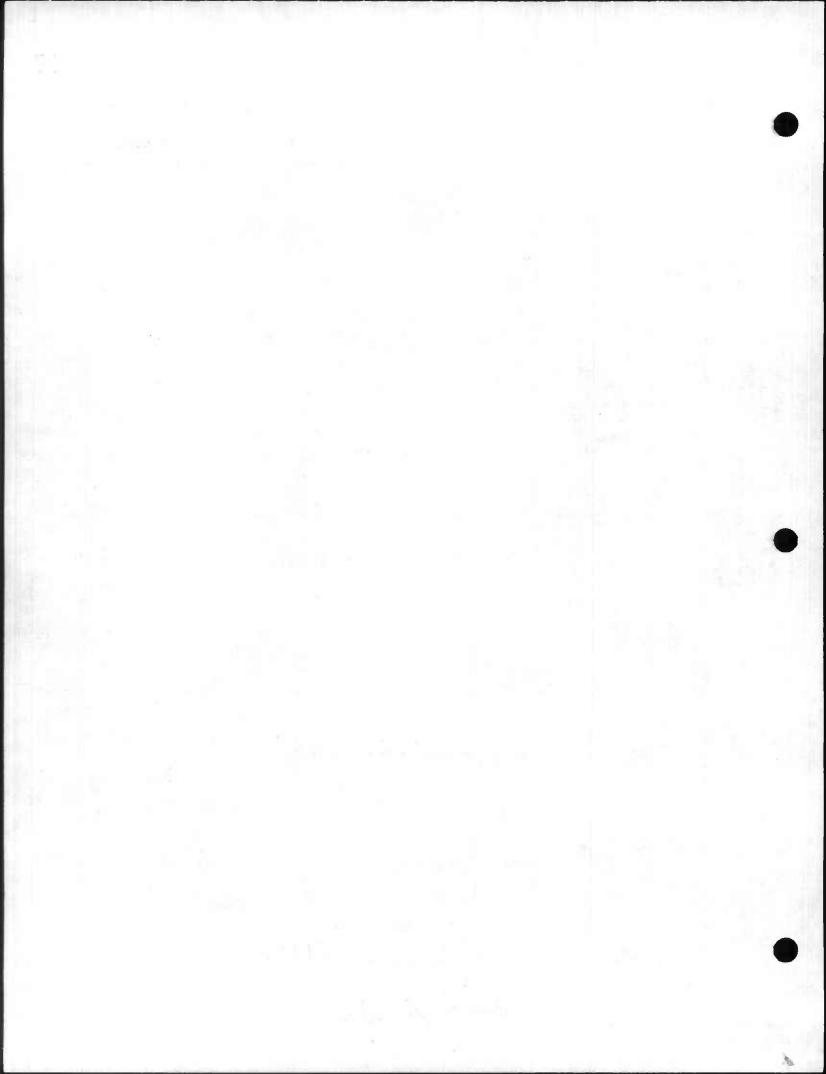
ant: If Item 27 is marked other than "neturel", or its ury or other traumatic event, the Medical Examine 1 Never Married 2 Merried Specify: White ammond, Harry Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Electrical power College (14or 5+) Elementery/Secondary (0-12) Engineer 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be William Hubert Hammond Clara Emma Miller 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 24879 Woods Drive, Denton, Maryland 21629 Ethel C. Hammond/wife 20b. Place of Disposition (Name of cemetery, cremetery or other place)
Capital Crematory 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 11/27/99 Dover, Delaware 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signalure of Funerel Service Lice 22. Name end Address of Fecility Moore Funeral Home, P.A. 10012 12 South Second St., Denton, Md. 21629 Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximete interval Between Onset end Deeth **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Physician/Medical Examiner treatment premou The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760, Discourance Due to (or as a consequence of) signed by the attending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 3 No 1 Yes t ☐ Yes 2 ☐ No Leus 25. Wes case referred to medical examiner? or Attending Physician: 26. Placa of Deeth (Check only one) Hospital: | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Death 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 128 Neturel 1 Tyes 2 No 24 hours after death.

Funerel Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Hospital To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the \$ 29b. Signeture, and talk of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence D. Bolian, MD, 606 Dutchman's Lane, Easton, Maryland 21601

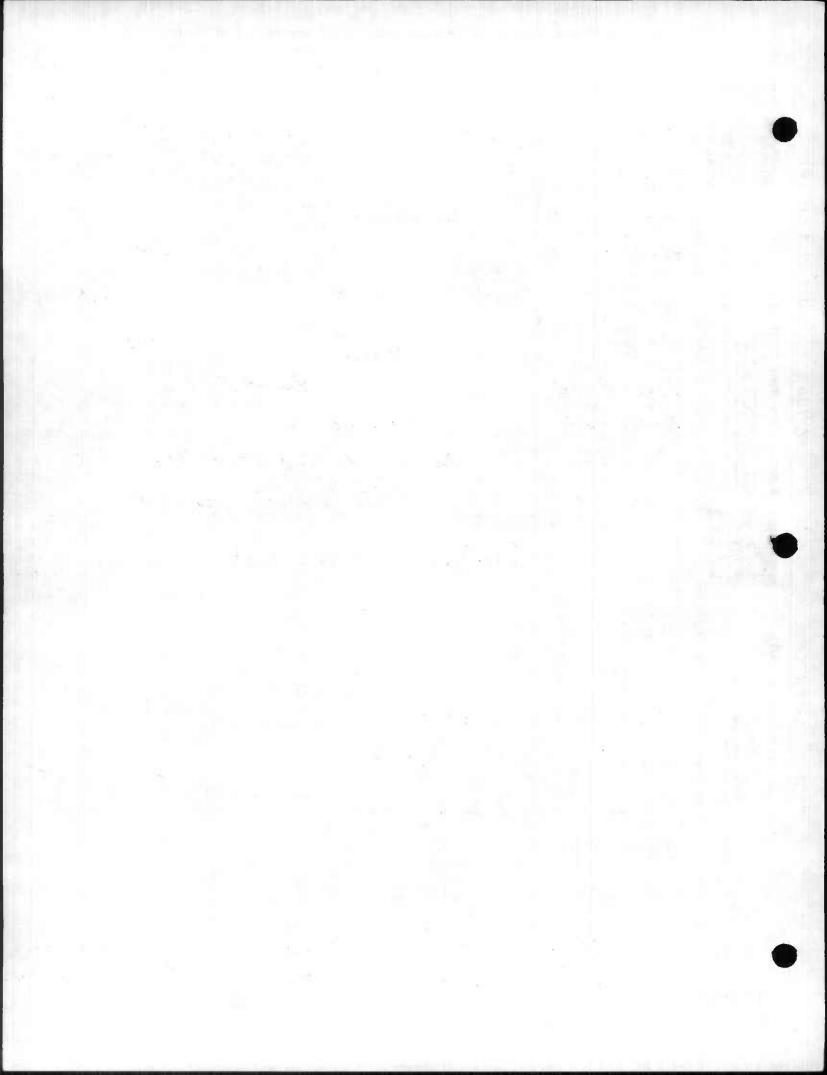
DHMH 16 Rev 6/95

State Registrar 32. Pégistrar's Signalure



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HINES SARAH **Physician** 0906 /Medical 4a Facility Name (If not institution, giva street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HAURE Se GRACE HARFORD MEM. HOSpital If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 9. Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Months Days LAZATIN 240-36-0215 Ai/27,1920 Director Usual Residence of Decedent 72 hours after death with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If Hem 27 Ia marked other than "natural", or Hems 23a or 28a-1 show ury or other traumatic event, tra Mexical Examines in the Incitited. 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits HARFORD HAURE de Grace 12 Yas 2□ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21078 U5A 464 BAHA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 220 No tf Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Biack, Whita, etc. 1 Never Married 2 Married Specify: BIACK 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE Hoase Wife 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HARNAH 19b. Malling Addrass (Syeet and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tinothy HINES 464 BAHERN 20b. Place of Disposition (Name of cemetery, crematory or other) 20e. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If Its any Injury or o Burlal 2 Cremation 3 Removal from Stata Donation 5 Other (Specify) and Address of Facility 21. Signatura of Funeral Service Licensee Disg Scott 552 Leuch 54 Have de Cepare, MI) 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Causa (Final Druvascular disaasa or condition rasulting in daath) Gh Examiner hour Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated avants resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Due to (or as a consequance of) SARAH Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Wara autopsy findings available prior to completion of ceuse of daath? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was cese referred to medical examiner? 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 20 No Certification: To 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ofter death Director: A d in by the f 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours oft Funeral Di detely filled in 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical To the Fune completely f (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifig Vovember 15,1999 8 Law Street , Xberdeen, Maryland 30. Name and address of person who completed cause of daath (Item 23a) (Type, Print) LXZXTIV M MANUEL MP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 17 1999

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month **Physician** 1:05 PM LIDA HERBERT 1 NOV. 21 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Planyland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Days 1□M 20 F 86 578-26-6896 Director OCT 13, 1913 North Carolina Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "natural", or items 23s or 28s-f show the Medical Exercises must be notified at 1 Yas 2 □ No Funeral Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 20603 USA 9295 Bolton Farm Place Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, Whita, etc. Pages 1 and 2 should be filed within 72 hours after nearl of Health and Mentel Hygiene.
ant: If Item 27 Is marked other than "natural", or the ury or other traumatic event, the Medical Exercine. 1 Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: white Completed by 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home Baitimore, Maryland 17 Father's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 James O. Land Nellie Davis Land 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Linda B. Bealle (daughter)
20a. Method of Disposition 9295 Bolton Farm Place 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stata Tourial 2 Cremation 3 Removel from State Department of important: If eny injury or page. Culpeper Nat1 Cem 11-29-99 Culpeper, VA 21. Signetyre of Funeral Souvice Licensee 22. Nama and Addrass of Facility M00173 Eberwein Funeral Services Entur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, is, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Medical Immediate Cause (Final disease or condition resulting in death) Previronia HOUY S Examiner Due to (or es e consequence of): by Physician/Medical Examiner burial-transit The lew requires that the death certificate be executed Due Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760 500 Due to (or es e consequence of): for USB as P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dehydration Division of Vitai Records, 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed Bradycardia this certificate has 1 ☐ Yes 2 No 1 Yes 2 No or Attanding Physician: director. 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2K No 28a. Date of Injury (Month, Day Year) funeral s after death. I Director: After the ed in by the funera 26d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Netural
2 Accident 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide filled in To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certified tul, DO H42445 MD 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Michael A. Piveutel, DO

Registrar

State

31. Date filed (Month, Day, Year)

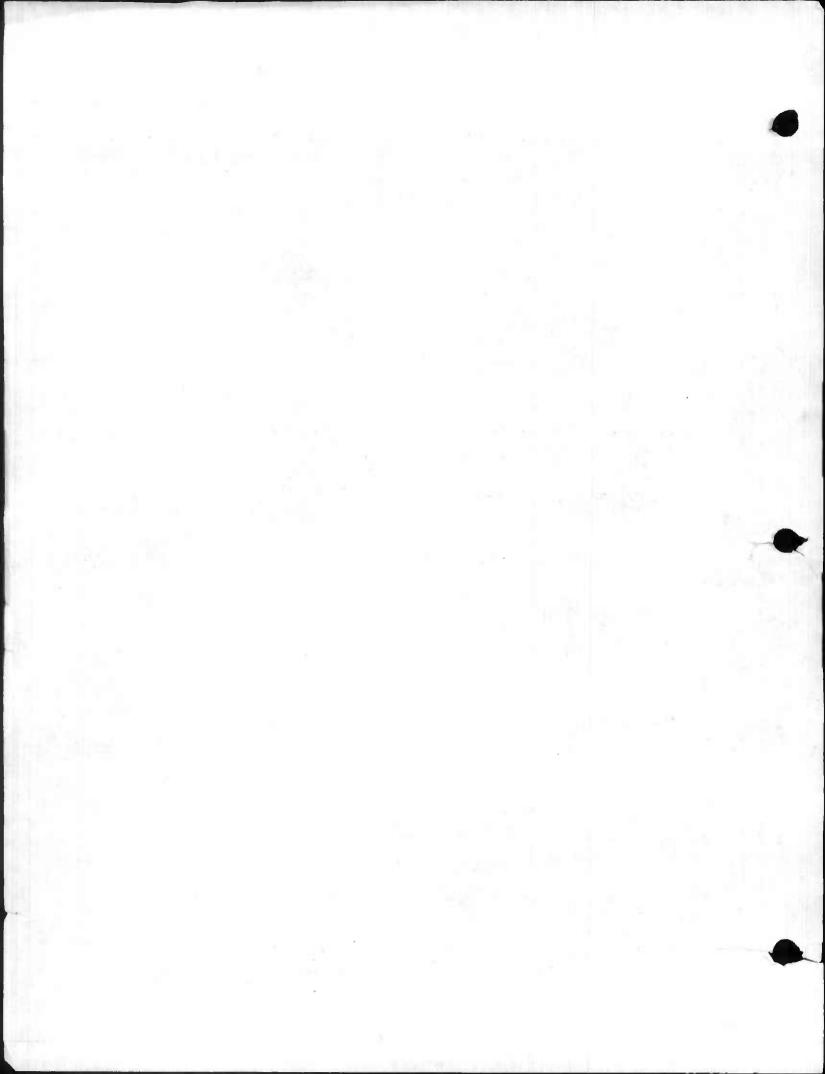
NOV 23 1999

books

32. Registrar's Signature

Depera

boi POST Office Road, 1-A Waldorf, MA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Deeth October 3, 1999 **Physician** Cristeene Johnson 1415 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Baltimore 8. Dete of Birth (Month, Dey, Year) Jan. 18, 1 5. Sociel Security Number If Undar 1 Yaar | If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthdey) 1 M 200 Months Deys Hours 219-28-5648 84 1915 Maryland Usuel Residence of Decedent 10a State 10c. City. Town or Location 10d. Insida City Limits 10b. County 1X Yes 2 No Directo Maryland Harford Havre de Grace 10g, Cifizen of What Country? 10e. Street end Number 10f. Zip Code 154 Bay Blvd. 21078 U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarlo Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amaricen Indian, 11. Merital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detes: 1 Never Married 2 Married 1 Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Shoe Manufacturing Inspector 12 18. Mother's Nama (First, Middla, Meidan Sumeme) 17. Father's Neme (First, Middle, Last) William Hipkins Anne Tarbert 19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 19e. Informent's Neme/Reletionship (Type, Print) Thomas Dale Johnson (Spouse) 154 Bay Blvd., Havre de Grace, MD 20b. Plece of Disposition (Neme of cematary, crametory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Church of the Ascention Cem. 10/7/99 Street, Maryland 21. Signature of Funeral Service Licenses 22. Nama end Address of Fecility Tarring-Cargo Funeral Home, P.A. 21001-3399 Aberdeen, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or raspiratory errest, shock, or heart failura. List only one causa on aach ma. Approximata Interval Between Onsat and Death Immediate Ceuse (Final disaasa or condition resulting in daath) Examiner ONGV Sequentially list conditions, if eny, laading to immadiate causa. Entar Undarlying Couse (Disaase or Injury that initiated evants resulting in death) Last Physician/Medical Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? Completed 24e. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Pieca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 27. Manner of Deeth 28b. Tima of 28d. Describe how Injury occurred Naturel 5 Pending investigation 1 Yes 2 Accident 3 Suicide 6 Could not be 28a. Place of Injury - At home, farm, straat, fectory, office building, efc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicide

1 Certifying Physician: To the best of my knowledga, daeth occurred et the tima, date end plece, end due to the cause(s) end menner es steled.

2 Medicat Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred et the tima, dete end plece, end due to the ceuse(s) end menner stated.

32. Registrar's Signature

29c. Licansa number

29d. Dete signed (Month, Dey, Year)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f.

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haalth and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23s or 28s-1 show

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examiner must be notified at

other

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Physician /Medical

Examiner

attending physician and for use as the burial-transit

signed by to

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certificate

State Registrar

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29a, Certifiai

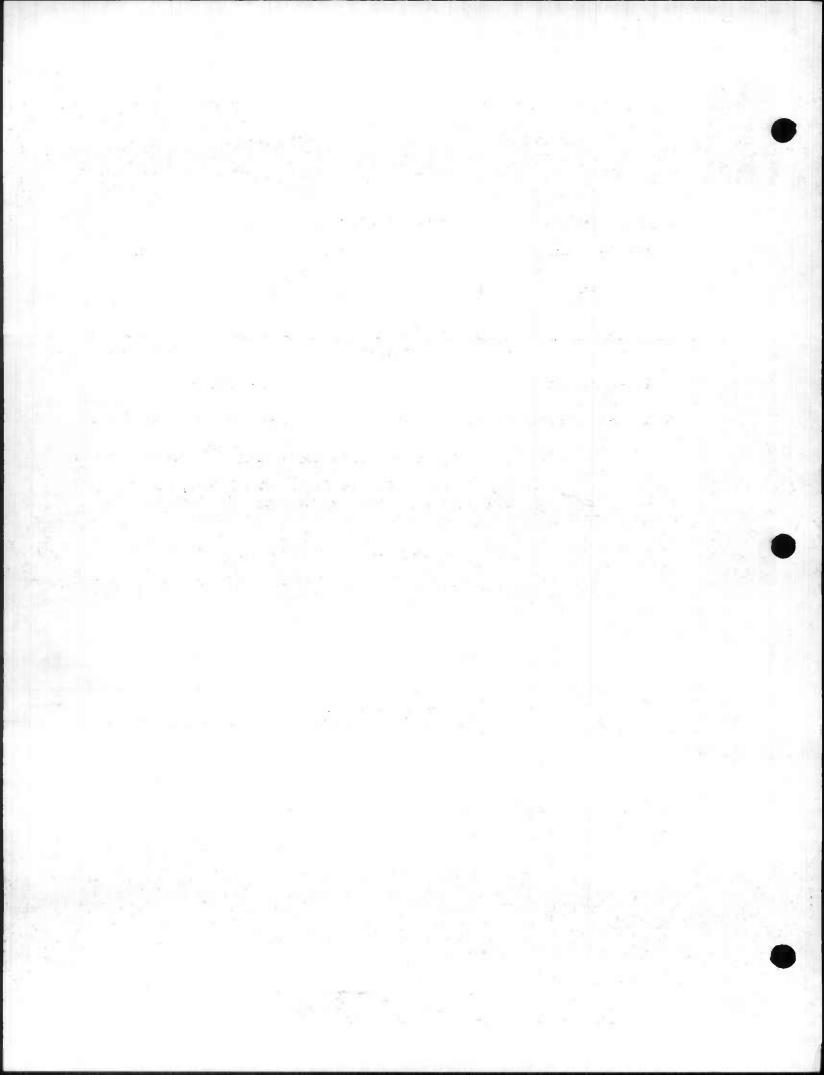
(Check only one)

29b. Signature end title of cartifie

30. Nama end eddress of person who

31. Data filed (Month, Dey, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month JOHN JAMES JONES SR. NOVEMBER 21 1999 4:00 P.M 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) NOV 17 1934 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days Hours 1€M 2□ F MARYLAND 220-30-8606 Yrs. Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 11400 BROWN HILL ROAD N.E. 21502 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas À XNo If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 6 OWNER/OPERATOR SALVAGE YARD SALVAGE YARD 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES RAYMOND JONES ESTELLA VIRGINIA BLOSS 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11400 BROWN HILL ROAD N.E. CUMBERLAND MARYLAND 21502 RUTH MAE JONES WIFE 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, State cematary, crematory or other place) 1 Burlal 2 Cramation 3 Ramoval from Stata SUNSET CEMETERY NOVEMBER 24 1999 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signatura of Funarat Sarvice License 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND art1. Enter the disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each lina. Approximata Interval Between Onset and Death Immediata Cause (Final METASTATIC COLON CANCER YEXRS disease or condition rasulting in death) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Directo

Funeral

2

Completed

Be

r than "natural", or items 23e or 28e-f ahov the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Madical Experience and a.

altimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital

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death

Examiner Physician/Medical þ Completed Be Medical Certification: To

that the death certificate be executed physician and is the buriel-trans signed by the page 2 should b Hospital or Attending Physician: this funeral After

25. Was casa referred to mulical 1 Yas 2 27. Manner of Death

1 Natural 5 Pending Invastigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

Hospital: 1 Thipatient

28b. Tima of

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Yes

26. Place of Death (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

2 [16

29b. Signature and tilla of certifiar 30. Nan

29a. Cartifier

(Check only one)

PITYSICUAN

29c. License number D 508 44

29d. Data signed (Month, Day, Year)

1 Tes 20 No

ion who completed causa of death (Item 23a) (Type, Print) . LOVERIA

NOVEMBER ULD 912 SETON DRIVE COMBERGON, MD 21502

State Registrar

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31. Data filed (Mooth

32/Registrar's Signatura

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

por & form

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Meredith November 20, 1999 Johnson 0800 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year 6. Sqx 1/2 M 2□ F If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 229-38-8952 80 06/01/1919 Indiana Usual Residence of Decedent 10a. State tOd. Inside City Limits 10b. County 10c. City. Town or Location 1 No 2 □ No Maryland | Somerset Princess Anne 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11720 Mansion Street 21853 USA Was Decedent Even Armed Forces? 1 Ness 2 No Myes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. Never Married 2□ Married 1 Yes Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Director Smithsonian 17. Father's Name (First Middle Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Nimrod Hoge Johnson II Josephine Hunt 19a. tnforment's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Shores 11720 Mansion Street, Princess Anne, Md. 21853 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 11/22/99 Salisbury, Md. 27) Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home WWW M00295 11673 Somerset Ave., Princess Anne, Md. 21853 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Vouvesolv. Immediate Cause (Finel 2 weeks disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Department of Important: If any Injury or

Physician

/Medical

Examiner

Funeral

Director

ral', or items 23s or 28s-f show Examiner must be notified at

"natural", or

Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. int: If item 27 la marked other than ' irry or other traumatic event, the Ma

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filed within 72 hours after

21215-0020

Baitimore, Maryland

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Examiner physician the burial Physician/Medical þ Completed

68760 Box P.O. Records, The Division of Vital death. after death Director: 6

Be Certification: To 27. Mennet of Death 1 Natural 2 Accident 3 Suicide 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier

State Registrar

31. Dete filed (Month, Day, Year)

(Check only one)

30. Neme and address of person who completed cause of de eath (Item 23a), (Type, Print) vargeli

32. Regis

28a. Date of Injury (Month, Day Year)

5 Pending investigation

6 Could not be determined

rar's Signature

28b. Time of Injury

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury st Work?

29c. License number

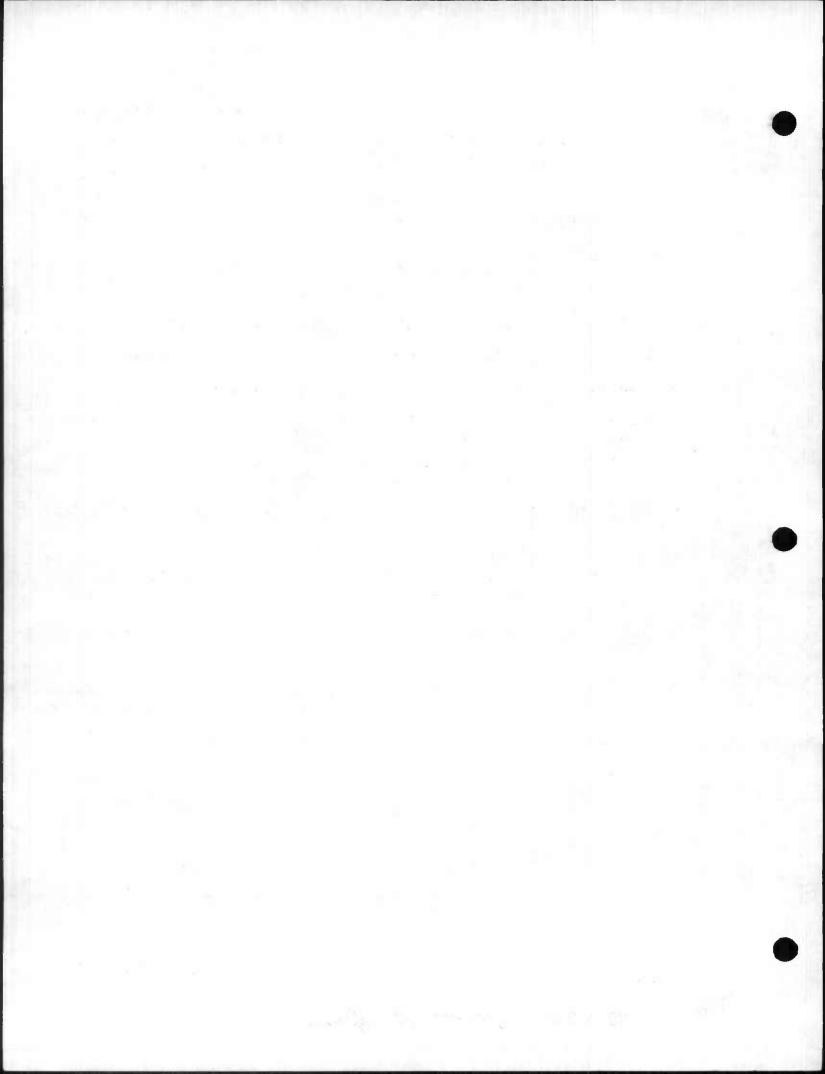
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner atated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number of Rural Route Number, City or Town, State)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Yaar November 19 1999 Jamison Jocelyn P. 0040 /Medical 4e. Facility Nema (If not institution, give straat and number) 4b. Cify. Town, or Location of Deeth 4c. County of Death Examiner Union Hospital of Cecil County Elkton If Under 1 Yeer | If Under 24 Hrs. | 8. Deta of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Aga (in yrs. last birthday) **Funeral** Birthpiaca (Stata or Foreign Country) 1 M 2 TF Days Yrs. Director 79 201-03-4162 September 5 1920 Pennsylvania Usual Rasidance of Decedant filed within 72 hours after death with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Director Delaware New Castle Middletown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 37 Ponderosa Drive Completed by Funeral 19709 United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, Whita, atc. 11 Maritai Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: 3 Midowed 4 Divorced Specify: white traumatic event, the Medical 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elamantery/Secondary (0-12) Coilaga (1-4or 5+) 4 Teacher Education 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 and 2 should be filt ment of Health and Mentel Hant: If item 27 is marked oth jury or other traumatic event Be J. Edwin Pecket Jocelyn L. Maconaghy 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Janet J. Henson 37 Ponderosa Drive, Middletown, Delaware 19709 20a. Method of Disposition 20b. Place of Disposition (Nema of cematary, crametory or other place) Data 20c. Location - City or Town, Stata 1 Buriat 2 Cramation 3 Ramoval from Stata 11/22/99 permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) Christiana, Delaware Christiana Presbyterian Cem. 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Fecility Hicks Home for Funerals, P.A. Sonald S H ules 103 West Stockton Street, Elkton, Maryland21921 23a. Part1. Enter the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiretory errest, shock, or haart failura. List only one cause on each line. Approximata Intarval Batween Onset end Deeth **Physician** /Medical Immediata Causa (Final disaasa or condition resulting to daath) Examiner Myocardial or Attending Physician: The lew requires that the death certificate be executed Sequantially list conditions, if eny, laading to immediata cause. Enter Undarfying Cause (Disaase or injury that initiated events rasulting in death) Last P.O. Box 68760, Physician/Medical Dua to (or es a consequance of) use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac Renal 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 s certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was casa referred to medicat Be 26. Placa of Death (Check only one) Hospital: 1 X inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 🕱 No Certification: To this 27. Mennar of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Panding Investigation 1 Naturel To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Cartifier Certifying Physician: To the bast of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. Medical completely 29b. Signetura and titia of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed causa of death (item 23e), (Type, Print) Omega Drive Newark De 19713

State Registrar 31. Deta fited (Month, Day, Yaer) 1 NOV 2 3 1999

32. Registrar's Signatura

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 37721.

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	1. Decedent's Name (First, Middle, Las	st)					te of Deeth		3. Time of Death	
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/Medical Examiner	4a Facility Neme (If not Institution, give street end number)				4b. City, Town, or Location of Dec			4c. County of D		
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	5. Sociel Security Number 6. S		yrs. lest birthday	If Under 1 \		kesville 24 Hrs. 8 Da	te of Birth	Carro	L.L. Birthplace <i>(State or Foreig</i>	
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PC CO				-						
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2 should and Mer is marke aumatic	19a. Informant's Name/Reletionship (7	Type, Print)	19b Meil	ling Address (S				city or Town, Stef		
d2 gd 2 g	Mrs. Rose Marie Ye							ille ,MI		
1 end Heelth em 27	20a. Method of Disposition		b. Place of Disp			Dat	-	c. Location - City		
	Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removel from State	cometery, cre Loudon 1	emetory or othe	r pleca)			altimore		
permit. Page Department of Important: If any Injury or page.	21. Signature of Funeral Service Licen	21. Signature of Duneral Service Licensee 22. Name and Address of Fecility HAIGHT FUNERAL HOME & CHAPEL, (PC Sykesville, MD 21784 (410)-795-1								
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dea ed lo	Part II. Other eignificant conditions co	ontributing to death but not	resulting in the	underlying caus	e given in Pert I.	. 2	3b. Did toba	cco use contrib	ute to the cause of death	
that the death ce hed by the ettendi detached for use y Physician/							1 Yes	2□ No 3□	Probably 4 DUnknow	
es the igned be de be de										
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has b									of death?	
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a Physical distriction of the TC	27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c.	Injury et Work?			injury occurred		
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To the comp	30. Name and address of person who of PATRICK TIDE	completed cause of deeth	(Item 23e) (Type	Print) CIB	CRTY F	ep e	ELDORS	SEURS U	10 2178y	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Items 1 & 26, per Phy. State of Maryland / Department of Health and Mental Hygiene 11/17/99, Carroll County, wjl Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Data of Death 3. Time of Death MARY LOU KRABLIN **Physician** 6 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howards' House 4949 Middleburg Rd. Taneytown Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Dey. Year) | Min. | Mar. | 15, | 1 9. Birthplace (State or Foreign Country) Illinois 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F 98 497-44-0549 Yrs. 1901 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner mast be notified at 1 ☐ Yes 2 🔯 No Carroll Union Bridge Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a any linjury or other traumatic event, the Medical Experiment 28a and the permit in the Medical Experiment 28a. 4234 Bark Hill Rd. 21791 Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Albert Horsley Ida Igo 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Union Bridge, MD 21791 Betty J. Adams/ daughter 4234 Bark Hill Rd. 20b. Placa of Disposition (Name of camatary, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☑ Removal from State Hoult Cemetery 11/20/99 Chrisman, IL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licensee arine Union Bridge, MD 21791 6 E. Broadway 23a. Part1. Enter the disaasa, or complications that cause the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on again Approximata Intarval Batween **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attanding physician and for usa as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical 83 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 7No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been s this cartificate has 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Domiciliary
6 NOther (Specify) Hospital: Other: 2 1 Yes 2P No 1 Inpatient 2 ER/Outpatient 3 DOA ■ 5 ☐ Residenca 28a. Date of Injury (Month, Dey Year) funaral 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury e Work? Certification: 5 Pending Investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

24 hours after death.

Funeral Director: After it ately filled in by the funeral or Attending Hospital complately within 2

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State Registrar

edical

31. Date filed (Month, Day, Year)

1999

4 ☐ Homicide

(Check only one)

30. Name and eddress of

29b. Signature and title of certif

29e. Certifier

OV 32. Registrar's Signature

completed cause of death (Item 23e) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0330

29d. Date signed (Month, Dey, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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ctor	5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year				
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Sire C	10e. Street and Number	ulloh Street		10f. Zip Code		1	0g. Citizen of What	Country?
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70	Herman Kamauff	Sens (Pri-4)	404 44 11	no Auldress (Or	Lanor Fitzp		China Tana	70000
To Be C	19a. Informant's Name/Relationship (7)	ype, mint)	19b. Madii	ry Address (Street	and Number or Run	w Moute Number	, City of Town, Stat	e, ZIP C00e)
	Charlotte Kamauff	Wife		Culloh Street	Fros	tburg		d 21532-
	20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	20b. Place of Dispo cemetary, crer	natory or other pla	ce)	Data	20c. Location - City	or Town, Stata
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ഗ്	25. Was case referred to medical axaminer?				26. Place of Deatl	(Check only on	e)	
	1 Yes 20 No	Hospital: Hnpatien	t 2 ER/Outpatier	t 3 DOA Ot	her: 4 Nursing Ho	me 5 Reside	nce 6 Other (S	Specify)
å	27. Manner of Death	28a. Data of Injury (Month, Day	28b. Tima of	28c. Inju			w injury occurred	777-1116
To Be	1 Pending 2 Accident		Year) Injury		Yes 2 □ No			
To Be	3 Suicide 6 Could not be							r Rural Routa Number,
To Be	3 Suicide 6 Could not be	building, efc.				City or Town	, State)	
To Be								
Certification: To Be	3 Suicide 6 Could not be determined	sician: To the heet of	my knowledge death	occurred at the fi	me date and place	and due to the ~	lilea(c) and manna	r as stated
Certification: To Be	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier 1 Certifying Physics	rsician: To the best of iner: On the basis of a	examination and/or inv	occurred at the tie restigation, in my o	me, date and place, opinion, death occurr	and due to the co ed at the time, do	use(s) and manna ate and place, and	r as stated. dua to the cause(s)
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edical Certification: To Be	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	iner: On the basis of a and manner state	axamination and/or in	29c. Licens	opinion, death occurr se number	ed at the time, d	ate and place, and one of the signed (Management of the signed of the si	onth, Day, Year)

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Olivaiowii 2		IIIsta	Morine Ku	hn	Ce	rtificate of	Death		Reg. No.	3/12/		
Dhysisia	_	cedent's Neme (First, Mide	dle, Last)					2. Date of Month	Death	3. Time of Death		
Physiciar /Medica		TRISTA	MARIE KU	HN				Nover				
Examine	de Pe	4a Facility Name (II not institution, give street and number) 12008 Harney Road						vn, or Location of De	eath 4c. Count	y of Death Irick		
	5 Soc	ial Security Number	6. Sex	7. Age (In yrs.	last hirthday	If Under 1 Year		sburg	Rieth	9. Birthplace (State or Foreign		
Funeral Director	214	-19-2308	1□ M 2Å F		6 Yrs.	Months Days		Min. (Month, APRIL	Birth Day, Year) 20,1983	GETTYSBURG, PA.		
9	10a. S	Residence of Decedent Stete 10b. Count	v	10c Cit	ty, Town or Lo	ncation				10d. Inside City Limits		
with the Maryland a or 28a-f show be notified at		RYLAND CARR		100.00		EYTOWN				1 ☐ Yes 2 ☒ No		
or death with the M Nerns 23e or 28e-f	10e. S	Street and Number				10f. Zip Code			10g. Citizen of	What Country?		
M Sa C		4460 BAPTI	ST RD.			21787	7		II.	S. A.		
Ting South	11. Ma	aritel Stetus	12. Wes De	cedent Ever in U	I,S. 13.			in? (Specify Yes or Puerto Rican, etc.)		ce - American Indian,		
2 1 2 1	1 1	1 Never Merried 2 Married 1 Yes 2 10 No				If Yes, specify Cut 1 ☐ Yes 2 ☒ No		Puerto Rican, etc.)		Black, White, etc.		
		☐ Widowed 4 ☐ Divorce	1 1 1 1 1	Dates:						WHITE		
S den	Eler	15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+)			16a. Dece	dent's Usual Occu kind of work done DO NOT use retin	ipation during most	of working	16b. Kind of Business/Industry			
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Pages 1 sent of H mt: If Ne nry or od		Mathod of Disposition Disposition Comparison	3 Removal from			osition (Name of metory or other ple	ece)	Date	20c. Location	- City or Town, Stete		
mit. Pager bartment of cortant: If I injury or		☐ Donetion 5 ☐ Other (W ST JO	OSEPH'S		11/24/9	9 EMMITS	BURG, MD.		
y in y	21. Si	gneture of Funeral Sarvice	Licensee / /. /	7	22	2. Name and Addr	ess of Fecility	CALLEC	FUNERAL H	IOME		
BEESS O	•	John 1	m. Shile	18				., EMMITS	BURG, MD.			
	23a	Part / Enter the diseesa, or shock, or heart failure. Lis	or complications that it only one cause on	caused the deat each line.	th. Do not ent	ter the mode of dy	ring, such es c	cardiac or respiretor	y arrest,	Approximate Intervel Between		
Physician						2				Onset and Death		
/Medical	diseas	Immediate Cause (Finel disease or condition						4				
Examiner		ing In deeth)	a	Due to (c	or as a consec	quence of):	/					
d ansit	5											
	B I Secue	entially list conditions,	0.	Due to (c	or as e consec	quence of):						
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at the death certific. d by the attending pletached for use as i			d									
death death of for	Pert II	Other significant conditi	one contribution to	death but not ree	ulting in the u	ndorhina cauca a	iven in Pert I	23h F	lid tobacco use co	ontribute to the cause of death?		
that the dead by the detached	E CONTE	Other significant concil	Continuous to	DOGIN OUT NOT 193	oning in the c	ildellying cause g	WORL WIT OF CI.		_ ~	3 Probably 4 Unknown		
- 5 DD									□ Yes 2/ZNo	3 Probably 4 Onknown		
requires								24a. W	/es an eutopsy	24b. Were autopsy tindings		
been s should									erformed?	available prior to completion of cause		
2 20 5	-									of death?		
The taste has page	3							P	Yes 2□No	Yes 2 No		
Physician: The ribis certificate and director, page 770 Ref.) ex	es case referred to medica aminer?						of Death (Check on	lly ona)			
A SE		D¥as 2□ No			ER/Outpatier	IL SLJ DOA		sing Home 5□R	0 00 00 0	1000.07		
After th funeral	27. Me	nner of Death □Natural 5 □ Pendi	ng 28a. Date	nth, Pay Year)	28b. Tima o Injury	Wo		Darco	be how injury occu	into totstrek		
Attending Per death.	2	Accident invast	igation ///	9/99	1548	M 10	Yes 200 N	000	e and Ca	ught fire		
r Att	40	☐ Suicide 6 ☐ Could ☐ Homicida deterr	nined 200. Filec	e of Injury - At he	ome, ferm, str	reet, fectory, office		28f. Liocatio City or	n (Street and Num Town, State)	ber or Rural Route Number,		

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Medical Certif

28e. Ptece of Injury - At hom building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannards stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier

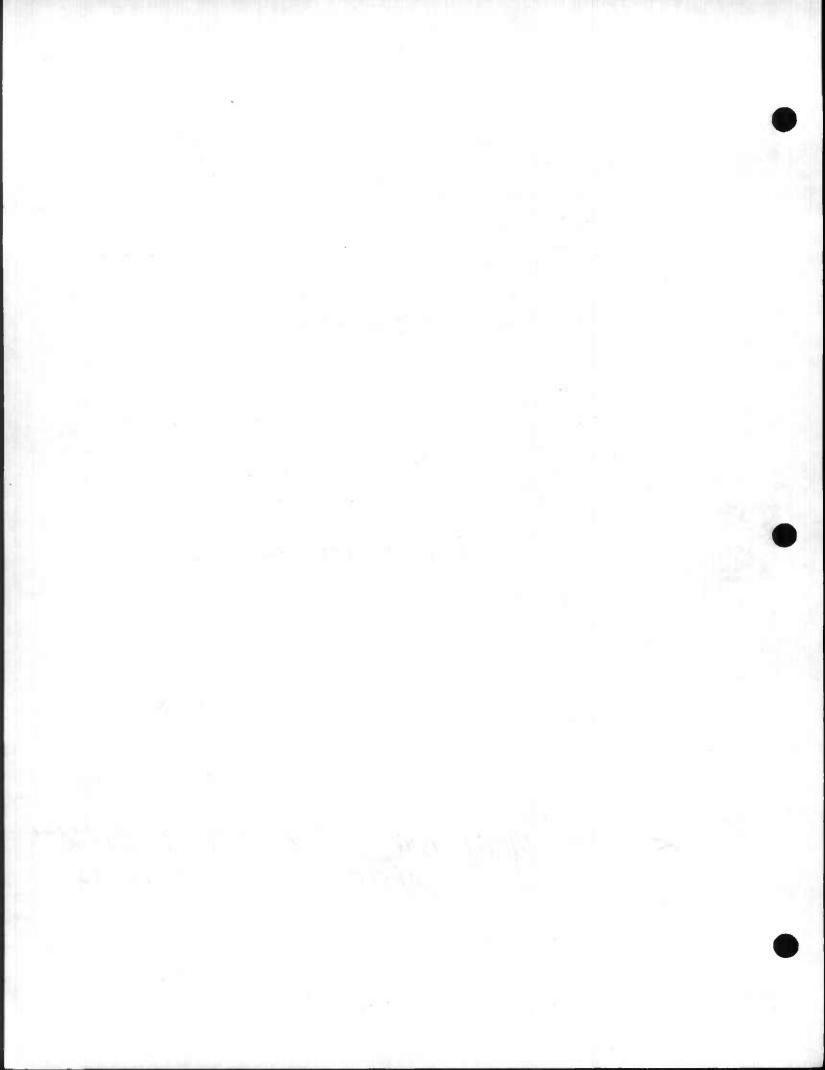
29c. License number O.C.M.E. 29d. Data signed (Month, Day, Year) November , 1999

30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registra's Signature 31. Date filed (Month, Day, Year) 32. Re NOV 2 2 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Yaeı **Physician** IMDEL illiAm VOVEMBER 8, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 18 M 2□ F 55-14-7808 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 1 ☐ Yes 2 No Director icomic 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 ROYA 234 14. Race - American Indian, Black, White, etc. Funeral Hema 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status Pages 1 and 2 should be filed within 72 hours effer 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: natural', or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: P Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) SEIFEMPLONED umber MAN 17. Father's Neme (First, Middla, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Ie marked other eny Injury or other traumatic event pages. 18. Mother's Neme (First, Middle, Meiden Sumame) Be 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) EAST Rd-Apt 102- Salsbury Kimber 1010 20b. Plece of Disposition (Name of cametery, cremetory or other) 20s. Method of Disposition 20c. Location - City or Town, Stele 1 ☑ Burial 2 ☐ Cremetion 3 ☐Removel from Stete FRIENdship Church Cam.
22. Name and Address of Facility Mg 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee SMITH FUNERAL HOME BENNIE 9.17-W. Isabelk St. Salisbury Md. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical signed by the eld be deteched for Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter death. director, 80 25. Was casa referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 npatient this 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending 1 Natural 1 Yes 2 No 2 ☐ Accident investigation efter death Director: 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or A within 24 hours efter To the Funerel Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

7808

55-14-

William

RIVEISIDE

of person who completed cause of death (Item 23a) (Type, Print) M.0

32. Registrar's Signature

560

29c. License number

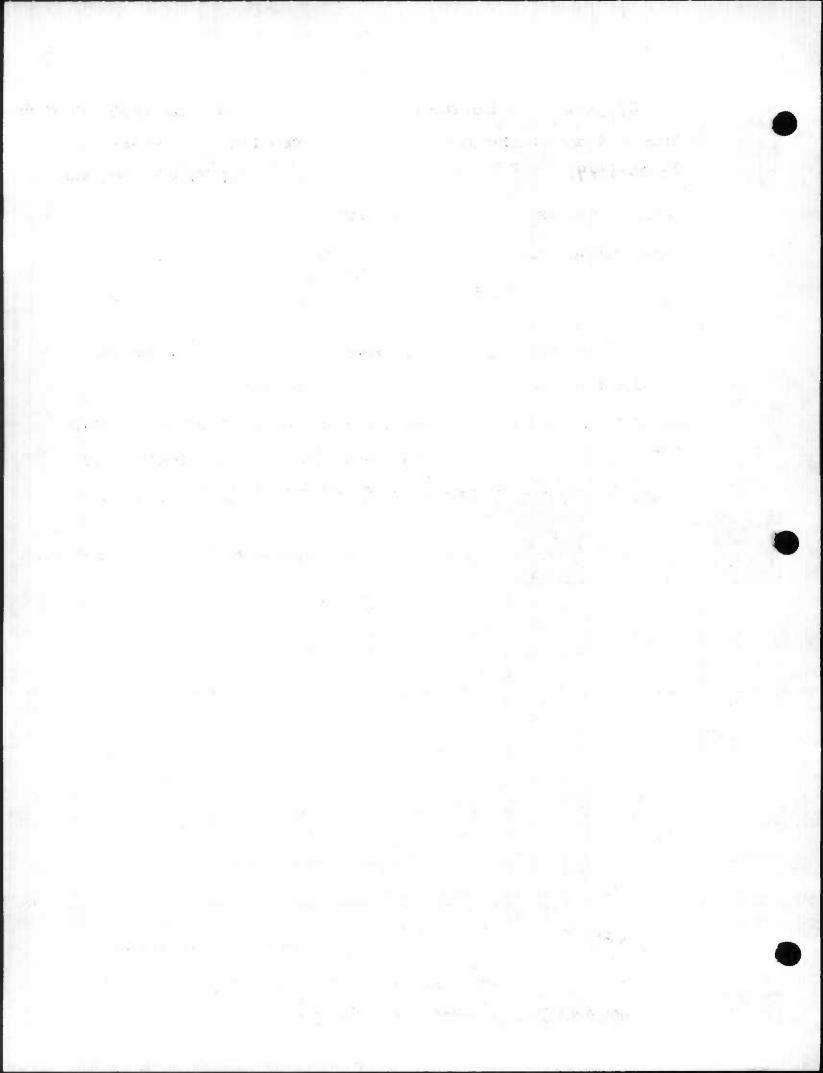
29d. Date signed (Month, Dey, Year)

PERLOT ADM

AND THE STREET STATES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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IN	ysicia Aedica amine	al	1. Decadant's Nama (First, Middle, L Al Venia 4a. Facility Nama (If not institution, gi	La	ndon		4b. City, Town, or L	2. Data of De Month	Day 21 19	Yaar 3. Tima of Death Of Death		
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Marylend -f show	ned at	tor	Usual Rasidanca of Dacadent 10a. Stata 10b. County Maryland Somers		10c. City, Town or I	Location Crisfield				10d. Insida City Llmits 1 ☐ Yas 2X No		
h with the	Mt De nou	Funeral Director	10e. Street and Number 26581 Mariners	Road		10f. Zip Coda	817		10g. Citizen of W			
5-0020 72 hours efter death with the Maryland netural', or flems 23a or 28a-f show	EXEMINAL UN	To Be Completed by	11. Marital Status 1 Navar Married 2 Marriad 3 🖾 Widowad 4 Divorced	12. Was Dacedant Et Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:		Was Dacedant of H If Yas, specify Cube 1 ☐ Yes 2 ☑ No	dispanto Origin? (Sp an, Maxican, Puarto Specify:	pecify Yas or No Rican, atc.)	Black	e - Amarican Indian, k, Whita, atc. White		
2121 1 within jiene.	The Medical		15. Decedant's E (Spacify only highast gr Elamantary/Sacondary (0-12)	ducetion ada complatad) Collega (1-4or 5+	16a. Decedent's Usual Occupation (Giva kind of work done during most of working			king	16b. KInd of Businass/Industry Garment Mfg.			
Maryland 212. d 2 should be filed within the and Mental Hygiene. 7 Is marked other than	2		To Be	To Be	To Be Co	17. Fathar's Nama (First, Middle, Less William R. Wils	son			Mae Lai	rd	, Maidan Sumame
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Baltime permit. Pag Department Important: It	once.		21. Signature of Phasel Sarvica Lice Robert H. Bra	dshaw, Jr	ss of Facility & Sons Fu in St C	Funeral Home - Crisfield, MD 21817 ardiac or respiratory arrast, Approximata Interval Batwaan						
Physica /Media Examin	cal		Immediate Causa (Final disease or condition rasulting in death)	a	Lerebro Va	sadar	acu'di			Interval Batwaan Onset and Death 2 MON/53		
(ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and 2 should be deated for use as the burdal-and	and and sa	ed G	Sequentially list conditions, if any, leading to Immadiata causa. Entar Undarfying Ceusa (Disaase or Injury that initiated avants rasulting in death) Last	C	ua to (or as a conse							
hat the death ed by the atterdal for a		Z Z	Part II. Other significant conditions o	contributing to death but	not resulting in the	undarlying causa giv	an in Part I.		~	tribute to the cause of death? 3 Probably 4 Unknown		
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SION sending eath. or: After	100	- -	27. Mapnar of Death 1 Natural 5 Panding 2 Accident invastigatio 3 Suicida 6 Could not b	28a. Data of Injury (Month, Day)	Year) 28b. Time (Injury	of 28c. Injun Worl	Ar: Nursing Ho y at k? Yas 2 No	28d. Dascribe I	now injury occurre	od .		
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To the Hospital within 24 hours a To the Funeral t completely filled	N	- [29b. Signatura and title of certifiar	and mannar state	d.	29c. Licanse				(Month, Day, Year)		
	State istrar		30. Nama and eddrass of person who DR · USHA NATESA 31. Data filed (Month, Dey, Year) NOV 2.3.10	completed causa of dea	th (Item 23a) (Type HALL s Signatura	Print) HIGHWA	y, CRISI	PIELI)	, MD 24	817.		



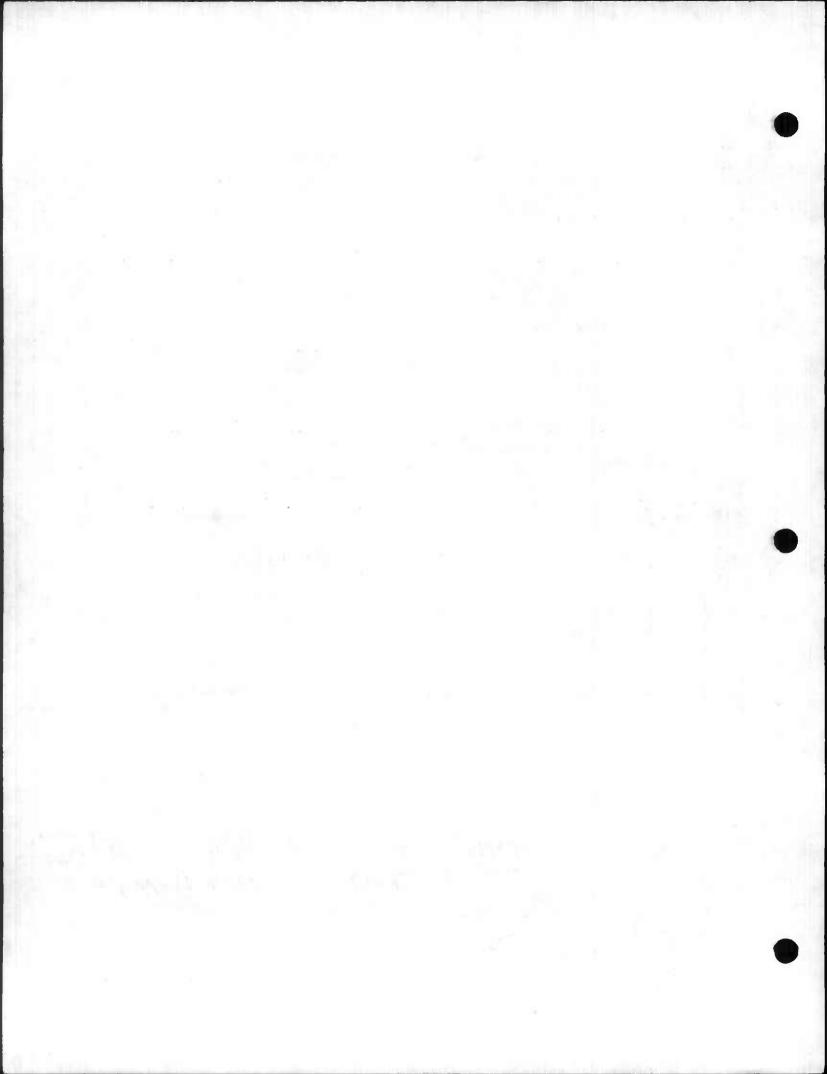
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	Physici	an.	1. Decedent's Nama (First, Middle, La	st)				2. Date of Death Month	Day	3. Tin	na of Death	
Ų,	Physici /Medic			INDY KAY	LOOK I	IGBILL		November	19,	1999 3:	55 P.M.	
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	Funeral Director		5. Social Security Number 6. S 214-19-0780 1 Usual Residence of Decedent	ex 7. Age	(In yrs. last birt	hday) If Under 1 Year Months Days		8. Data of Birth (Month, Day, Y FFB 20, 1		9. Birthplace (St Country) GETTYSBUI		
	after deeth with the Maryland or items 23e or 28e-f show miner must be notified at	Director	10s. State 10b. County MARYLAND CARROL		10c. City, Town	ANEYTOWN					de City Limits Yas 2 XNo	
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21215-0020	or he	by Fur	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Ves Give		in U,S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:				k, Whita, atc.		
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		S	17. Father's Nama (First, Middle, Last)	2		COLLEGE STU	DENT 18. Mother's Name			COLLEGE		
Maryland	0 2 0 6	To Be		MICHAEL LOC	OV TNOD T							
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altimore,	ges 1 and it of Healt if Nem 2 or other		20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other pla				City or Town, Stat	a	
Ĕ	Part of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		NEW ST	. JOSEPH'S	11/24/9	9 EN	MITSB	URG. MD.		
Bailt	pemil. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licen	ERAL H	OME	E115						
	Physician /Medical Examiner		23a Parr / Enter the disease, or complete, or heart leiture. List only Immediate Cause (Finat disease or condition resulting in death)	olications that caused the cause on each line of the cause on each line of the cause on each line of the cause of the cause of the caused the c			ing, such as cardiac o			Approx	imata I Between and Death	
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2	after desti Director: d in by the	Ē	4 ☐ Homicide determined	building, etc.	(Specify)	COLLET		City or Town, S	tate)	. Do	vointour,	
	To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by	Medical C	29a. Certifier 1☐ Certifying Phy Medical Exam	rsician: To the best of iner: On the basis of a and manner state	xamination and	death occurred at the ti	ime, date and place, a opinion, death occurre	and due to the caus	se(s) and ma and place, a	nrier as stated.	ise(s)	
	To th Within To th	Me	29b. Signature and title of certifier	MD			se number .M.E.		Date signed Iovembe	er, 19		
			J. Laron Locke			Type, Print) 11 Penn Sta	reet, Balt	imore, Ma	rylan	d 21201		

State Registrar

J. Laron Locke M.D.

31. Date filed (Month, Day, Year)

NOV 2 2 1999



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death LUCAS Month **Physician** 1152 IDA NOV 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL | SHADY GROVE ADVENTIST HOSPITAL | HUnder 1 Year ROCKVILLE MONTGOMERY 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1 M 2 KF Yrs. 514-22-8533 **Director** Dec 4 1912 KS Usual Rasidance of Decedent 10a. Stata 10c. City, Town or Location 10d. tnside City Limits Nerna 23s or 28s-f show the Medical Examiner must be notified at 1 MYes 2 □ No Director MD Montgomery Poolesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17213 Chiswell Road 20837 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. hours after 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva "natural", or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 Housewife Domestic 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Pages 1 and 2 should be nent of Health and Mental is marked Norman D. Garrett MAY ALBERTA LEWIS 2 19a. tnformant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health as Important: If Item 27 is any injury or other tra-N. Kay Brown/daughter 17213 Chiswell Road Poolesville, MD 20837 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burlal 2 Cramation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Othar (Specify) 11/22 Enders/Shirley FH Berryville, VA 21. Signature of Funaral Sarvice Lin 22. Nama and Address of Facility Hilton Funeral Hôme Box 86 Barnesville, MD 20838 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart feilura. List only one cause on each line. Approximata Intervat Between Onset and Daath Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical KESIRATORY FAILURE 2 DAYS Examiner Due to (or as a consequence of): Examiner COMA 2 DAYS be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last attending physician and for use as the burial-tran Dua to (or as a consequence of): ACUTE CEREROVASCULAR ACCIDENT Box 68760. 2 DAYS Physician/Medical Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0.0 signed by the 4 Unknown 1 Yes 2 No 3 Probably þ Records, 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy completion of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certification by the funeral director. Be 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 20 No Certification: To (B) patient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death (SNatural 2 Accident 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending invastigation 1 Yes 2 No 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide • Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Cartifier Medical within 24 hor To the Fune completely fi (Check only one)

State Registrar 29b. Signature and title of ceptiler

Mendrell

SAXENA VIRENDRA 31. Data tiled (Month, Day) 1999 Signeture

CRITICAL CARE CONSULTAN

aroon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1// PNDRA SAXINA 7100 Deer Crossing

29c. License number

030112

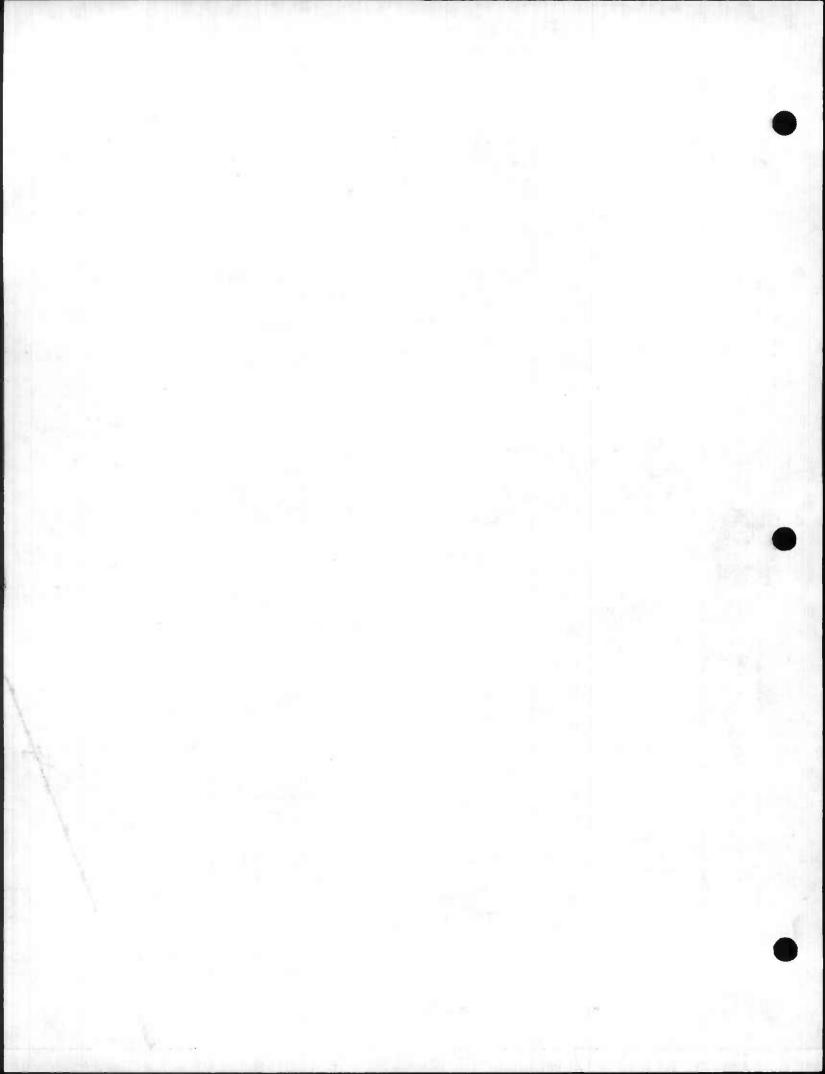
Court, BETHESDA

29d. Data signed (Month, Day, Year)

NOV 20

1999

å



Amended Item #21, Per F.D., and Item 23a, Part I, per Phy., 11/17/99, Carroll County, wjl Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** NOV. 6:45 A.M. JAMES ELMER 16, 1999 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecllity Neme (If not institution, give street end number) **Examiner** 1215 North Carroll Hampstead
| If Under 24 Hrs. | B. I
| Hours | Min. | Street Carroll If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys **X** M 2 □ F Months Director 73 212-26-1765 Jun 27 1926 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, tra Medical Examiner must be notified as 1 XYes 2 □ No Directo MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1215 North Carroll Street 21074 Funeral USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc 1 ☑ Yes 2 ☐ No tt Yes, Give Yeer or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within; Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "n any Injury or other traumatic event, the Medians. Elementery/Secondary (0-12) College (1-4or 5+) Hahn's Westminster 11 Shift Supervisor 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Howard Taft Emma Gertrude Mays Mays 19e. Interment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Plece of Disposition (Name of cemetery, cremetory or other place)

1215 N. Carroll St. Hampstead, MD 21074

20c. Location - City or Town, Stete Paula L. Mays, Wife 20e. Method ot Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 11-17 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Inc Hampstead, MD 21. Signature Funeral Service Licensee 22. Name end Address of Fecility M00550 Eline Funeral Home 23a. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart tailure. List only one cause on each line. 21074 Approximete Intervel Between Onset and Deeth **Physician** 2 MONTHS Brenchoalveolar Cell Checinoma of Lung /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) Examiner Examiner physician end s the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence ot): P.O. Box 68760 Physician/Medical Due to (or es e consequence of) attending | 88 Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? been signed by t should be datact 1 Yes 2 No 3 Probably 4 Unknown ATRIAL hariLLA na Division of Vital Records, by 24b. Were eutopsy findings evelleble prior to completion of ceuse of death? Completed 24a. Was en eutopsy performed? is certificate has b 1 Yes 20 No 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Wes case reterred to medicel exeminer? Be 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 27. Manner of Deeth 28b. Time ot 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated. edical 29a. Certifier 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) K. Calvin III, m 031660 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) WESTMINETER MO 21157 GALVINIM HOMAS 295 STONEZ AVE. 31. Dete tiled (Month, Dey, Yeer) 32. Registrer's Signeture State Registrar NOV 17

DHMH 16 Rev 6/95

MOV 17 800 James 1st Secret

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edward Morningstar November 16 1999 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Carroll County General Hospital Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday)

Feb. 21,1926

295 Stoner Ave. Suite 102 Westminster MD

Maryland

Funeral Director

Physician

/Medical

Examiner

Ralph

220-18-0913

Usual Residence of Deceden

18 M 2□ F

Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Int: If them 72 is a merked other than "hatureft, or terms 23a or 28a-f ahow ury or other traumatic avent, the Healthal Engine ment to notified any or other traumatic avent, the Healthal Engine ment to notified a Baltimore, Maryland 21215-0020 permit. Page Depertment of Important: If any Injury or

Physician /Medical Examiner

physicien end the buriel-transit 98 950 signed by the all page 2 certificate Hospital or Attanding Physician: funeral director, After this efter death.

Division of Vital Records, P.O. Box 68760,

10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Westminster 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 U.S.A. 510 Geneva Dr. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck driver Transportation 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Reuben H. Morningstar, Sr. Helen Giggard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 510 Geneva Dr., Westminster, MD Susan J. Morningstar - wife 21157 20b. Place of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardns 11/19/99 Finksburg, MD 22. Name and Address of Facility 21. Signature of Funeral Servica License Hartzler Funeral Home 310 Church St., NEw Windsor, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BOWEL ISCHEMIA disease or condition resulting in death) Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) PANCREATITIS Physician/Medical Due to (or as a consequence of). HYPERTENSION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No COPD à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy ASCVD completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer?
1 ☐ Yes 2 No Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifie 29c. License number D21942 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

SARVA

31. Date filed (Month, Dey, Yeer)

GIRDHAR

NOV 1 7 1999

MD

32. Registrar's Signature

MON 1 2 1383 Proin influence

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. Amended Items 3 & 26 per Phy. State of Maryland / Department of Health and Mental Hygiene 11/17/99, Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4b. City, Town, or Location of Death **Physician** Russell Franklin Myers /Medical 4a Facility Neme (If not institution, give street and number) Examiner | Baltimore
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Months | Days | Hours | Min. | Sept 29 1 Sinai Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 10 M 20 F 89 212-03-4132 1910 Director Usual Residence of Decedent 2058ellFMYeRS 10b. County 10c. City, Town or Location Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code herrs 23a or 2211 West Rogers Avenue 21209 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 🏖 ☐ Married 1 Yes 2 No If Yes, Give X Year or Dates: "natural", or 1 Yes 2 No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) USF & G Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic eve Frank P. Myers Mae Rineman 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louella Myers/wife 2211 West Rogers Ave Baltimore, MD 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 12 Burial 2 Cremation 3 Removal logn State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cem 11/16/99 Pleasant ValleyMD 21. Significure of Funeral-Service Boensee 22. Name end Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, and Entering disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or heart failure. List only one cause on each line. **Physician** Cerebro Voscular Dylase /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or es e consequence of):

P.O.

Records,

Division of Vital

Physician/Medical þ Completed To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 89 Medical Certification: To

certificate

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

MD 21157

Approximete Interval Between Onset and Death

7:31 a.m.

9. Birthplace (State or Foreign Country)

White

10d. Inside City Limits

1 Yes 2 No

1 Yes 2K No

1 ☐ Yes 2 No

25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 1 Yes 25 No (Varsing Home 5 | Residence 6 | Other (Specify) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident

3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

lebelt, us. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

BALTO, md 21224 ROBERT LIBERTO, 3508 BANK ST mo. 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

MON 12. 18.7 June 1 June 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month **ALVENA** VIVIAN MCKINNEY 17, 1999 November 0300 a.m. /Medicai 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Westminster Nursing & Rehab. Center Westminster Carroll 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth (Month, Dey, Year | 75 Yrs. | Months | Days | Hours | Min. | June 3, 19 5. Social Sacurity Number Birthplece (State or Foreign Country) **Funeral** 1□M 20 ¥F 213-16-5552 Director Pennsylvania Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show Carrol1 Maryland Westminster Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1234 Washington Road 21157 United States Completed by Funeral death 12. Was Dacadant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Datas: 11. Marital Status Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, atc.) Race - American Indian, Black, White, atc. Pages 1 and 2 should be filed within 72 hours effer of ent of Health and Mental Hygiene. nnt: If Item 27 is marked other than "natural; or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced white th and Mental Hygiene.
7 is marked other than "natur traumatic event, tre Medical 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) stitcher rubber factory 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Melden Surname) Be Emory Nu11 Mamie Bollinger 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Larry R. McKinney / 4009 Littlestown Pike Westminster, MD 21158 If item 27 or other t 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition Nov. 20 20c. Location - City or Town, Stete 1 X Burlal 2 Cramation 3 Removal from Stete Department of important: If any injury or once. Grace U.C.C. Cemetery Taneytown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 1999 21. Signature of Funaral Service Licensee 22. Name end Addrass of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787 win 23e. Pert1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immedieta Causa (Finel 10 cl diseesa or condition resulting in daath) Examiner Physician/Medical Examiner The law requires that the death certificate be executed the bunel-transit Sequentially list conditions, if eny, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in deeth) Lest P.O. Box 68760. Dua to (or es e consequance of): use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yss 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, à page 2 should Completed 24e. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of ceuse of daath? After this certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Wes case referred to medical 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 M Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No Certification: To the funeral 27. Mennar of Deeth 28a. Data of Injury (Month, Dey Yaar) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of 5 Pending Investigation 1 🖾 Naturel To the Hospital or Attandil within 24 hours after death. To the Funeral Director: A completely filled in by the fu deeth. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and mannar as stated.

2 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and mannar stated. 29a. Certifier Medical one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30 Name and eddress of person who completed cause of daeth (Itam 23e) (Type, Print) Westminster, md 21157 mW 31. Dete filed (Month, Dev. Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

MIN I R 1959 Several to Spiritary

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

BELLA	
MATHEW	IS

Physician /Medical Examiner

Funeral

Director the Maryland show.

r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at I Hygiene.

21215-0020

Baltimore, Maryland

P.O. Box 68760.

Division of Vital Records.

filed within 72 hours after permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other treumatic avant, III

Pilysician /Medical Examiner

Examiner The law requires that the death certificate be executed Physician/Medicai tha 8 signed by þ Be Completed director, page 2 should certificate has To the Hospital or Atlanding Physician: 1 v. Fin 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p edical Certification: To

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Betty Anne Matthews 11:22P.M. NOVEMBER 24, 1999 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year)
Dec. 22, 1959 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Months Days 1□M 2X F Hours 39 213-80-7087 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits Baltimore 1 ☐ Yes 2 XNo Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3223 Old North Point Rd. 21222 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. I ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife 11 Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer R. Rhoten Patsy D. Cox 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3223 Old North Point Rd., Baltimore, MD David L. Matthews/husband Nov. 29, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Carmel Cemetery Parkton, MD 1999 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
J.J. Hartenstein Mortuary, Inc.
24 Second St., New Freedom, PA 21. Signature of Funeral Se vice Lice Lenstern 17349 disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel H6 dominal disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chermato, & arthutes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 'bernohed 12 Yes 2 □ No 1 Deres 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident

3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 11-24-99 6 Could not be

28b. Time of Injury 2026 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No person in wheelchair struck Location (Street and Number or Rural Route Number, City or Toym, State) 7 - Belle

4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end mayner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) NOVEMBER 25, 1999

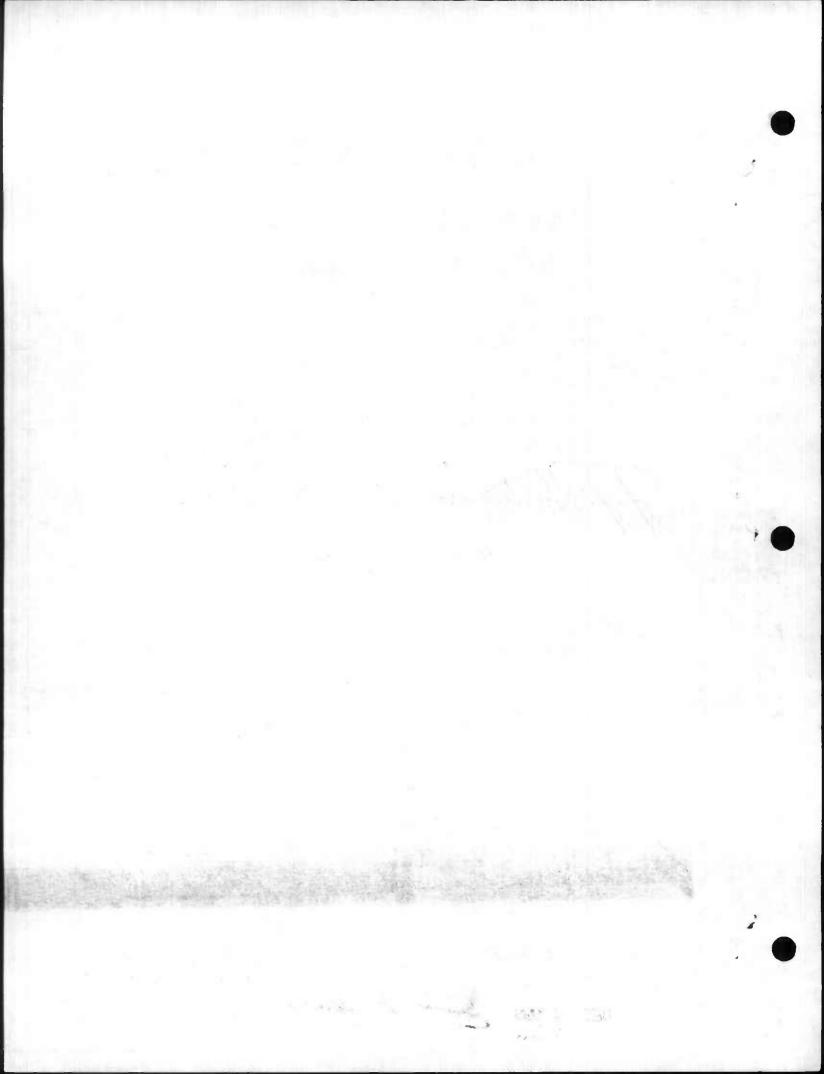
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ennis J-Chuteno

hann

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Dey, Year) DEC

32. Registrar's Signature



MEPL

MD.

62. Registrer's Signeture

2 3 1999

CUMB.

MD.

21205

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

(15) -1 E (1 1 E)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth Month Day Year NAOMI 19, 1999 4c. County of Deeth MURPHY NOVEMBER 23:10 PM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Sacred Heart Hospital Allegany Cumberland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days Months 1□M 250F 214-07-6336 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 17213 Mount Savage Road, N.W. 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 farmer dairy farm 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Francis "Frank" Aldridge Elizabeth Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George A. Murphy Maryland 21532-17213 Mount Savage Road, Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Sunset Memorial Park 23-Nov-99 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Fecility en Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a, Dart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on sech line. Approximete Intervel Between Onset and Death Immediate Cause (Final 15 months disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings aveilable prior to completion of causa of death? 24a. Wes an autopsy Failure 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be 2

Funeral

Director

death with the Meryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show shipury or other traumatic avant, the Medical Examina must be notified at page.

Baltlmore, Maryland 21215-0020

The law requires that the deeth cartificate be executed physician s the burial Box 68760. 8 P.O. 1 signed by the eld be deteched for Division of Vital Records.

Examiner Physician/Medical P Completed 8

Certification: To 27. Manget of Death Medical

To the Hospital or Attanding Physicien: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

hus State

Registrar

6

28a. Dete of Injury (Month, Day Year)

29c. License number 14464

28c. Injury at Work?

1 Yas 2 No

1
| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Dascribe how injury occurred

NOV. 20. 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sikander Sandhir, M.D., 48 Tarn Terrace, Frostburg, Maryland 21532

31. Date filed Novy 2 2 2 1999

29b. Signature and title of certifier

1 Yes 2 No

5 Pending

investigation

6 Could not be

1 Natural

2 Accident 3 Suicide

4 Homicide

29a, Certifier

32 Registrar's Signature

1 1 Inpetient 2 □ ER/Outpatient 3 □ DOA

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28b. Time of

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the state of the same of

200) . C. VAV.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Lest) 2. Data of Daath Month MILBOURNE DENNIS E.

Physician Funeral Director

15, November 1999 6:00 A.M. /Medical 4e. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner Crisfield** 7 Goodsell Alley Somerset 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpleca (Stata or Foraign Country) Days 10XM 2□ F 216-56-0999 47 Yrs. Maryland Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. Its Madical Essentials. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Somerset Crisfield Maryland ¥ Yas 2 No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7 Goodsell Alley 21817 U.S.A. Funeral 12. Was Dacedent Evar in U,S. Armed Forcas? 1 (XY) As 2 □ No 1972-If Yas, Giva Yeer or Datas: 1976 Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Navar Marriad 2 ☐ Married 21215-0020 Specify: White 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ♣ Divorced Completed Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) Elamantary/Secondary (0-12) 12 Collega (1-4or 5+) Machinery Parts Mfg. Owner Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Jack E. Milbourne Patsy Riggin 19a. Intormant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Patsy M. Sterling (Mother) P. O. Box 190 - Crisfield, MD 21817 20a. Method of Disposition 20b. Plece of Disposition (Neme of cematary, cramatory or other place) 20c. Location - City or Town, Steta 1 ☐ Burial 2 ACrametion 3 ☐ Ramoval from Stata Salisbury Crematory 11/16/99 Salisbury, MD 4 Donation 5 Othar (Spacify) 22. Nama and Addrass of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, J. 306 W. Main St. - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Batw Onsat end Death **Physician** /Medical Immediata Cause (Final 2mo disaasa or condition rasulting In deeth) Examiner Due to (or as a consequanca of): Examiner The law requires that the death certificate be executed burial-transit Sequantially list conditions, if eny, laading to immadiata causa. Enter Underlying Causa (Disaase or Injury that initiated avents rasulting in daath) Last Dua to (or es a consaguance of) attending physician for use as the buria Box 68760, Physician/Medicai Dua to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? been: certificate has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to completely filled in by the funeral director, to Be 25. Was case referred to madical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Yas 2 No 3□ DOA 27. Mannar of Daeth 1 Natural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: 28d. Dascribe how injury occurred 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicida 6 Could not ba 28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 4 Homicida 1 🖫 Certifying Physician: To tha bast of my knowladga, daath occurred at tha time, dete and placa, and dua to the ceusa(s) and mannar as stated. 29a. Certifian Medicai 2 Medical Exeminar: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signatura end title of cartifiar Licansa number 29d. Date signed (Month, Day, Year) 199 30. Name end eddre s of pe completed cause of deeth (Item 23e) (Type, Print) RNSO 20 145 E. Carroll St. - Salisbury, MD 31. Data filed (Month, Dey, Yeer) 32. Registrar's-Signatura State Registrar 9 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Month November 18,1999 Roscoe Baker 12:50 AM Martin 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Citizens Nursing Home Frederick Frederick If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) March 27, 1 5. Social Security Number If Undar 1 Yaar 6. Sax 1X M 2□ F 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months Days Yrs. 1908 91 Maryland 219-20-0348 Usual Rasidanca of Dacedant 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yes 2 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 200 West 12th Street 21701 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Married 2X Married 1 ☐ Yas 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b Kind of Rusiness/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) General Store 7th Merchant 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meidan Sumema) Tobias Peter Martin Stella Mae Baker 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zlp Code) 23421 Slidell Road, Boyds, Maryland Stanley R. Martin - Son 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 □ Cramation 3 □ Ramoval from Stata Pleasant Hill Cemetery 11/21/99 4 ☐ Donation 5 ☐ Othar (Specify) Monrovia, Maryland 21. Signatura of Fynaral Sarvica Licensee 22. Nama and Addrass of Facility Olin L. Molesworth P.A., Funeral Home 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate Approximate Approximate Immediate Ceusa (Final disaasa or condition rasulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaguança of): Dua to (or as a consaquanca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Les 24b. Ware eutopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? 2 No

Physician /Medical Examiner

that the death certificete be execu

Division of Vital Records, P.O. Box 68760,

The

Hospital or Attending Physician:

To the

After this

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within 24 hours efter de To the Funerel Directo completely filled in by th

Physician

/Medical

Examiner

10a, Stata

Directo

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, in Medical Examinet must be not the appropriate.

Baltimore, Maryland 21215-0020

Examiner physicien end s the buriel-trensit 100 use lor signed by the e page 2 hes certificate funeral director,

Physician/Medical þ Completed Be 2 Certification:

5 Panding

investigation

6 Could not be daterminad

25. Was casa rafarred to medical axaminar?

1 Yes 2 No

27. Manner of Death

2 Accidant

3 Sulcida

(Check only one)

29e. Cartifiar

4 Homicida

Hospital:

28e. Pleca of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

26. Piece of Deeth (Check only one) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

1 🗲 certifying Physician: To tha bast of my knowladga, death occurred at tha tima, data and placa, and dua to tha causa(s) and menner es stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29b. Signatura and title of certifier

29c. Licansa number

1 Yes 2 No

29d. Data signed (Month, Day, Year)

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

reduct, md NOO1 200 mB eleer 1999 Ragistrer's Signatura

Registrar

Medical

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death Month Olive Virginia Moser 10 Ve 4e. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Boons boro Fahrney - Keedy 5. Social Security Number 6. Sex Home If Undar 1 Year 9. Birthplace State or Foreign Country 1905 Maryland Memorial 8. Data of Birth (Month, Dey, Year) Tully 9, 19 7. Age (In yrs. last birthdey) Months Days Hours Min. 1□M 2♥F Yrs. 1905 94 214-74-4022 Usual Rasidenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Frederick Myersville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 10834 Harp Hill Road 21773 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yas, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: white Specify: 3 ☑ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grada completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 8 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Surnama) George B. Mullendore Jennie Arnold 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 10818 Harp Hill Rd., Myersville, MD 21773 Francis Moser/ Step son 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetary, crematory or other place) 20c. Location - City or Town, State 1 € Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion United Methodist 11/18/99 Myersville, Maryland 21. Signature of Funeral Service Licenser 22. Name and Address of Fecllity Ricketts Funeral Home 504 Main St., Myersville, MD pulsations that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, one cause on each line. Approximate nterval Betw Onset and Deeth Immediate Cause (Finel diseesa or condition resulting In death) 3-4 m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Centro varanto Academor 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 | Yes 2 | 3-No

Examiner The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, physician certificate has Attending Physician: director.

Examiner Physician/Medicai þ Completed Be 2 Certification: Director:

Physician

/Medical

Examiner

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Director

28a-f show

Director

Funeral

Completed by

Be

7 is marked other than "natural", or items 23s or 28s-f shov traumstic event, the Moulcal Examiner must be notified at

marked other than "natural",

Hygiene.

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The end Mental Hyr.
The mark-

Pages 1 and 2 should I

permit. Pages 1 and 2 s Department of Haelth or Important: If item 27 is any Inlury or other trau

Physician

/Medical

27. Manner of Death

1 (Natural

2 Accident

3 Sulcide

29a, Certifier

4 Homloide

(Check only one)

5 Pending investigation

6 Could not be determined

28e. Dete of Injury (Month, Dey Yeer) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

Location (Straet end Number or Rural Route Number, City or Town, State)

1 Cartifying Physicien: To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier -told ms

29c. License number D(8019 29d. Date signed (Month, Dey, Yeer) NN 15, 1995

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

VASANT DATTA, MD 344 MILL ST. HAGERSTOWN, MD 21740

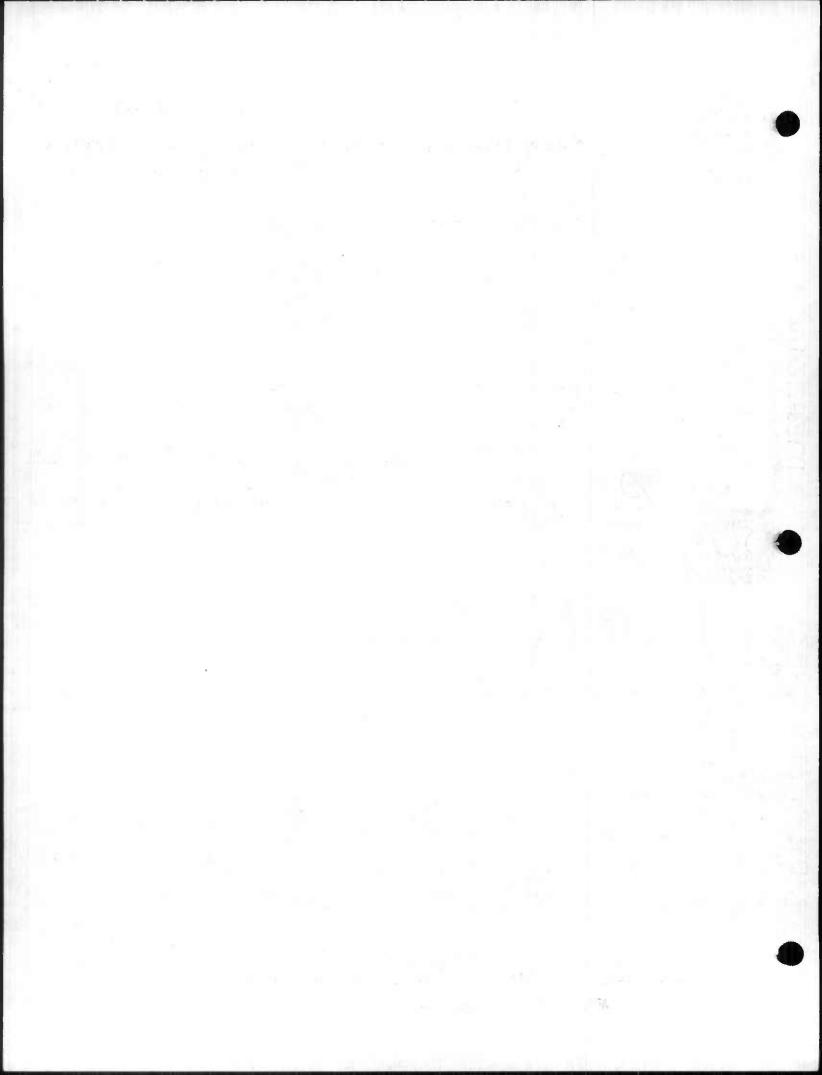
State Registrar 1999^{32. Registry & Signature}

After this

within 24 hours at To the Funeral DI complataly filled is

Medical

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Line 1, jd fchd Reg. No 1. Decedent's Name (First, Middla, Last) 2. Date of Death NOV. 1 2 **Physician** LLNDA LYNDA MARIA MYERS 1999 10:33A /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 101 WEST SOUTH ST APT. FREDERICK FREDERICK Hours Min. 8. Date of Birth (Month, Day, Y)
MAR . 21 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days Months 47 NEW YORK 1□M 2√2F 091-40-9500 52 Yrs **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD. FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 101 WEST SOUTH ST 21701 U.S.A. 238 Funeral death Harns : 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZNO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Maritai Status Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yes 2 No Specity: à 3 Widowed 4 Divorced Year or Datas: 'natural' Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry il Hygiena. Elamantary/Secondary (0-12) Collega (1-4or 5+) HOUSE WIFE HOME 12 TH Peges 1 end 2 should be filed w tment of Health and Mental Hygien tant: If item 27 is marked other ti jury or other traumatic avant, 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLEO KEEFE ROSE MARIE DETHOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 Depertment of Health a Important: If item 27 Is any injury or other tra CLAUDE G. MYERS 101 WEST SOUTH ST APT 6 FRED. MD. 2170 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State METRO" CREMATORY 1 ☐ Buriai 2 Cremation 3 ☐ Removal from State 11/16/9BALT. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 21701 110 WEST SOUTH ST. FREDERICK. 23a. Part 1. Enter the disease, or complice shock, or haar fatura. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, causa on each line. Approximate Interval Batween Onset and Death Physician Immediata Causa (Final disease or condition resulting in daath) /Medical 2 wells Examiner Dua to (or as a consequenca of) Physician/Medical Examiner cure chama The law requires that the death certificate be executed use es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or Injury that Initiated events Due to (or as a consaquence of) metastatie Box 68760, Colo physician Due to (or as a consequenca of) resulting in death) Last P.O. I Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? detached signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 90 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 should Completed 24a. Was an autopsy performed? has certificata 1 Yes 2 1Vo 1 Yas 2 10 or Attanding Physician: Be 25. Was casa referred to medical 26. Placa of Death (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent Othar: 4□ Nursing Home 5□ Residence 6 □ Other (Specify) Certification: To 1 Yes 2 No 3□ DOA this 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Panding investigation ours after death. ners! Director: Af filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Phyalcian: To tha bast of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29h Sig 29c. License number 29d. Date signed (Month, Day, Year) pleted causa of daath (Itam 23a) (Type, Print)

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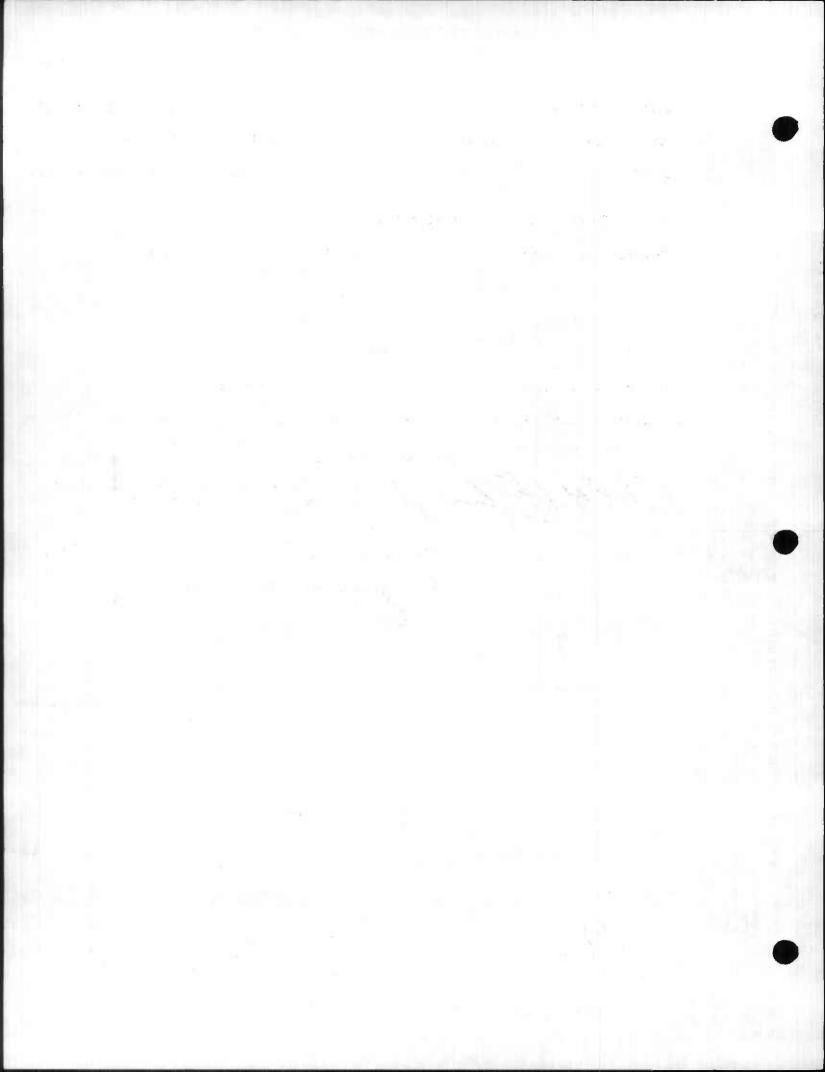
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1999 Julia Mae Mattes Nov 14 9:40 PM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, giva street and number) Examiner Corsica Hills-Genesis Eldercare Queen Anne's Centreville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (Steta or Foreign Country) **Funeral** Days Hours 1□M 2\ F Months Director 202-03-3417 83 June 2, 1916 Pennsylvania Usual Residence of Decedent death with the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Queen Anne's Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Armstrong Avenue 21617 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status Peges 1 and 2 should be filed within 72 hours after onest of Health and Mental Hydjene.
Intel filter 27 le marked other than "naturel", or literary or other traumatic avent, the Medical Exam in ☐ Yes 2 No f Yes, Give 1 ☐ Never Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: à 3 ☑ Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 9 Homemaker Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Arthur Shipe Ella Stecker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Whitman - Daughter 26370 Arcadia Shores Circle, Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1999 Nov. 15, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If eny Injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center LLC. Stevensville, MD 22. Name and Address of Fecility 21. Signature of Funerai Sarvica Licensas Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619 and state and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part 1. Entar the diseasa, or complishock, or heart failure. List only, Approximata Interval Between Onset and Death **Physician** /Medical N Immediate Cause (Final angrene disaase or condition resulting in death) Examiner Examiner sheral ician and burial-transit law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of): physician s the burial DivIsion of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) ding p usa etten ō signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ been sig 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? certificate has t director, page 2 s 1 Yes 2 2No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Daath (Chack only one) Other: Surring Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Naturel 2 Accident 5 Pending Investigation after death. 1 Tyes 6 Could not be determined To the Hospital or Atterwithin 24 hours after des To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner stated. 29a. Certifier 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and title of continue 132036 who completed cause of death (Item 23a) (Type, Print) 30. Name and address (and Drive Check, My 21619 2108 32. Registra/s Signature 31. Date filed (Month, Day, Yaar) State NOV 1999 Registrar

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Dr. Tariq Mahmood, 2300 D
31. Date filed (Month, Day, Year) 32. Registrar's Signature DV 1 7 1999

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 Dulaney Valley Road, Timonium, MD porks

ORIGINAL

29c. License number 1)43725 29d. Date signed (Month, Day, Year)

11/16/99

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Month November 19 John Taitt McCain 800 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner F1kton If Undar 24 Hrs. Hours Min. Union Hospital Sex XXM 2□ F If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 179-12-8252 Director March 19,1917 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mentel Hygiene. nt: If Hem 27 is marked other than "naturel", or frems 23e or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or Nems 23e or 28e-f show traumatic event, "na Medical Examinar mast be notified as 1 ☐ YesX X ☐ No Director Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1280 Irish Town Road 21901 USA by Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status VTYYes 2 □ No MYes, Give Year or Datas: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2☐(No 3€Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completad) Air Compressor Rental Co. Elementary/Secondary (0-12) College (1-4or 5+) 12 Owned Businesses Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Be George McCain 2 Sarah (Unknown) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1280 Irish Town Road, North East, MD 21901

e of Disposition (Name of Date | 20c. Location - City or Town, State other t Jack W. McCain (Son) 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 0 permit. Page Department of Important: If any Injury or once. Philadelphia Crematories 11/22/99 Philadelphia, PA 21. Signature of Funeral Service Licent 22. Name and Address of Facility Beeson Memorial Services 2053 Fulaski Highway, Newark, DE 1970 23a. Part1. Enter the disease, or complications that shock, or heert feilure. List only one cause on Approximate Interval Between Onsat and Death **Physician /Medical** Immediate Cause (Final - Non Small dell disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last end the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria Physician/Medical Due to (or as a consequence of) signed by the el d be detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by page 2 should 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peed completion of cause of death? After this certificate has 1 Yes 2 No 1 ☐ Yes 3 No tal or Attending Physician: The star death.

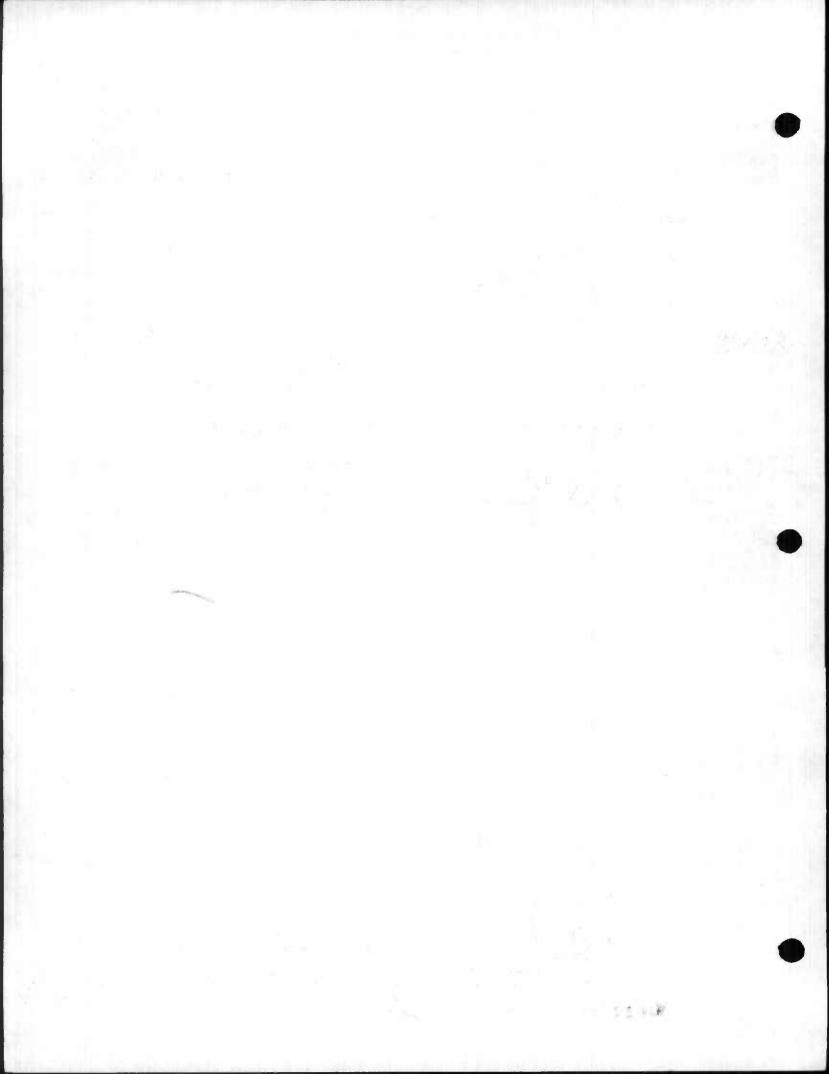
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2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License numbar D3 5 6 5 3 29b. Signature and little of certi 29d. Date signed (Month, Day, Year)

32. Registrar's Signature

111 W. High St. #104, C

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year 18, 4:30 PM Lenora Newcomb Nov. 1999 4a. Fecility Nema (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Deeth Princess Anne Somerset 11714 Mansion Street 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year 7/18/1924 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 1□M 2 F Months Days Hours Yrs. 75 218-14-2428 Usuel Rasidence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Somerset Princess Anne 10e. Street and Number 10f. Zin Code 10g. Citizen of Whet Country? 11714 Mansion Street 21853 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (ENo If Yes, Give Yaer or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Ricen, atc.) 14. Raca - American Indien, Bleck, Whita, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16e. Dacedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) College (1-4or 5+) 12 3 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Surnama) Walter Mobray Dula Benton 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 11714 Mansion Street, Princess Anne, Md. 21853 Darwyn Newcomb/Husband 20e. Method of Disposition 20b. Plece of Disposition (Name of camatary, crematory or other pleca) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory 11/19/99 Salisbury, Md. signatura of Funeral Service/Licansee 22. Neme end Addrass of Facility Hinman Funeral Home 11673 Somerset Ave., M00295 Princess Anne, Md. 21853 er1. Enter the diseasa, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or raspiretory errast, hock, or heart feilure. List only one ceuse on aach line. Approximete Interval Between Onset and Deeth Immediete Ceuse (Final RS diseese or condition resulting In deeth) Dua to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initioted avants rasulting in deeth) Lest Dua to (or es e consequenca of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? rt I. 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 X No

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death with t Department of Health end Mentel Hygiene. In T2 hours after death with t Important: If Item 27 is marked other than "natural", or items 23a or 2 and hyl Injury or other traumatic event, the Medical Examiner messenges.

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28e. Dete of Injury (Month, Dev Year)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify)

28c. Injury et Work? 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29a. Certifian

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29b. Signature and title of cartifiar

25. Wes case rafarred to medical examiner?

1 ☐ Yes 250 No

27. Manner of Deeth

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State Registrar

Medical

1999 NOV 2 3

5 Pending Investigation

6 Could not be determined



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Deeth Month Voor November 19, 1999 4b. City, Town, or Location of Death 4c. County of Death | Conowingo | If Under 1 Year | If Under 24 Hrs. | | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 1⊠M 2□ F Yrs. 46 1953 Maryland

1. Decedant's Nama (First, Middla, Last) 3. Tima of Death **Physician** David M. Nichols 6:15 PM /Medical 4a. Facility Nama (If not institution, giva street and number) Examiner 500 Block Mt. Zoar Rd. 5. Social Security Number **Funerai** Birthplace (Stata or Foreign Country) 215-58-2286 Director Usual Rasidance of Dacedeni death with the Maryland 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Moulcal Examiner must be notified at 10d. Insida City Limits Director 1 X Yas 2 □ No Maruland Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 104 Bayland Dr. Unit #19 Funeral 21078 USA 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours eiter o Inopartment of Health and Mental Hygiene. Inportant: if item 27 Is marked other than "natural", or item any Injury or other traumatic event, the Meucal Enamers once. Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorcad White Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Chef Food Service 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Leff C. Nichols Irma A. Jones 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Jessica D. Nichols/Daughter 48 Locomotive Lane Colora, MD 21917 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 X Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) West Nottingham Cemetery 11-23-99 Colora, Maryland 21. Signature of Funeral Service Licenses 22. Name end Addrass of Facility T. Foard Funeral Home, P. A. 1 S. Queen St., Rising Sun, MD 21911 23a, Part. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such es cardiac or respiretory arrast, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medicai Immediata Causa (Final disaasa or condition rasulting in death) Examiner Dua to (or es e consequança of) Physician/Medical Examiner siclan end burial-frensit The law requires that the death certificete be executed Sequantially list conditions, if any, laeding to immadiate causa. Enter Underlying Causa (Disease or Injury that Initiated avants rasulting in daath) Last Dua to (or es a consequenca of): P.O. Box 68760, physician s the buria Due to (or es e consequança of): 98 ate hes been signed by the e pege 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 Unknown Division of Vital Records. þ Completed 24b. Wara eutopsy findings availabla prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yas 2 ☐ No or Attending Physician: director. Be 25. Was case rafarred to medical 26. Placa of Death (Check only ona) axeminar? 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 8 Nother (Specify) in the woods Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA After this the luneral 28a. Date of Injury (Month, Day Year) 27. Mannar of Deeth 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 5 Panding investigation 1 Naturel within 24 hours after death.

To the Funeral Director: All completely filled in by the It. 1 Yas 2 No 2 Accident 3 Sulcida 4 ☐ Homicida 6 Could not be datarminad Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, straet, fectory, offica building, atc. (Spacify) Hospital Medicai 1 Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and placa, and due to the cause(s) and manner as steted.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the tima, data and placa, and due to the ceuse(s) 29a, Cartifian and manner statad. å 29b. Signature and file of certifier 29d. Dete signed (Month, Day, Year)

of death (Item 23e) (Type, Print)

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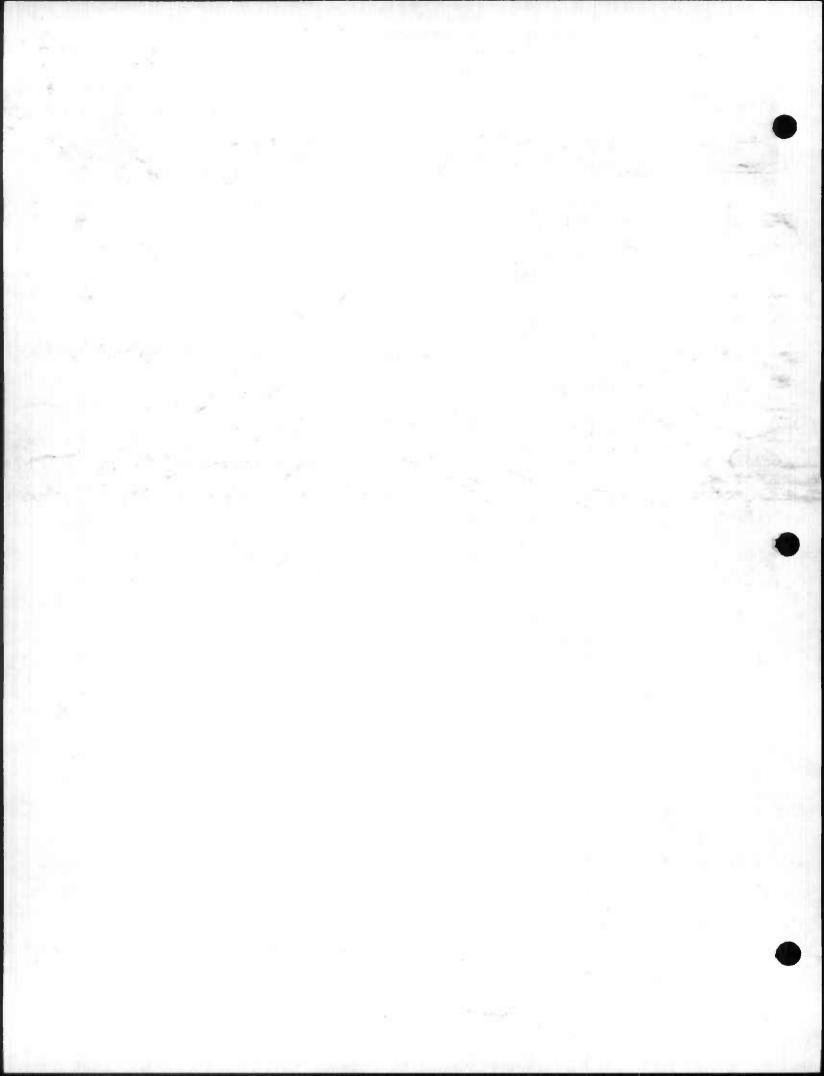
32. Ragistrar's Signature

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30. Name and eddrass in

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Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other treumatic event, the Head cell Earth once. To Be Completed by F	1 Buriel 2 Creme 4 Donetlon 5 Oth		emovel from State	0	lan Cem	ourer prac	1	11/22	Cente	will.	e PA
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£ 8	MICHON Cumberland, Maryland 2,502										
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer fellure. List only one cause on each line.										Approximate Interval Between
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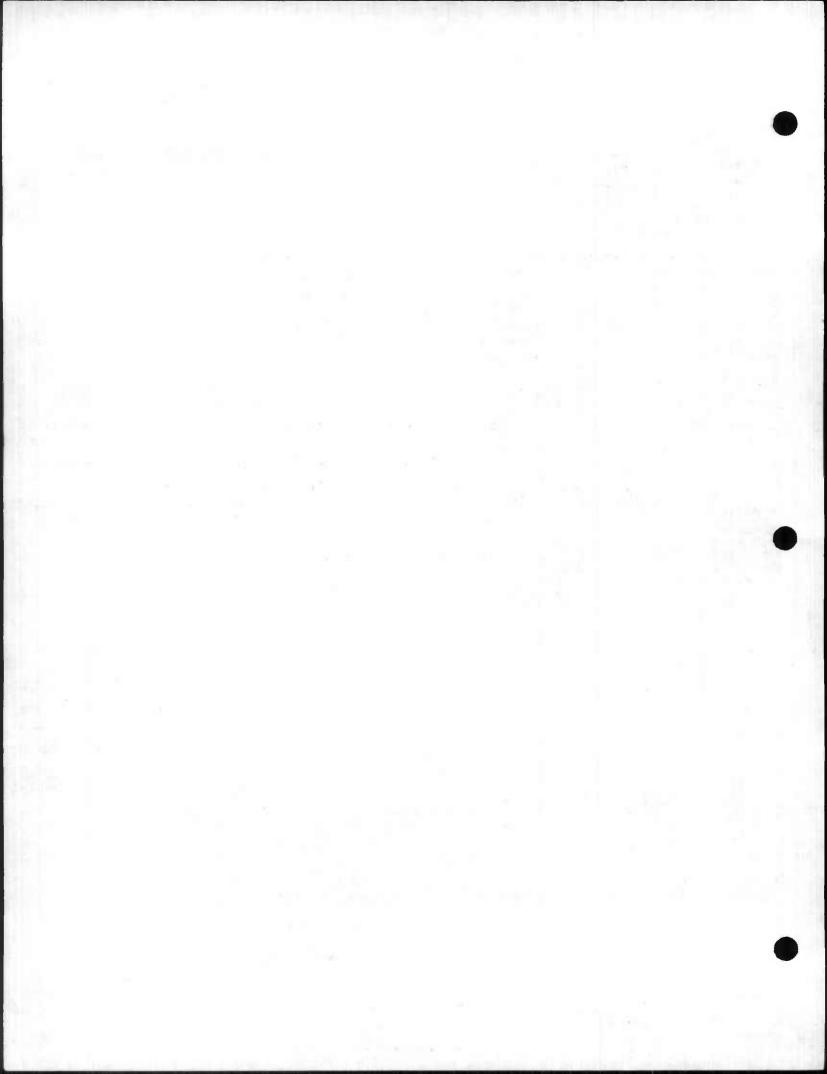
State of Maryland / Department of Health and Mental Hygiene -Reg. No. QQ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day Physician November 19,1999 Pear1 Pa₁mer 9:05 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) 1914 N. Carolina 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 204 Days Months Hours 578-26-3572 85 Director January 11, Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Frederick Director Maryland | Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? homs 23a 13695 Lexington Drive Funeral 21771 U.S.A. 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. r than "natural", or hen the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after Hygiene. ther then "naturel", or its 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. ğ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Dress Shop Manager 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mantai Hy Important: If Itam 27 is marked oth any injury or other traumatic event. 17. Father's Nama (First, Middle, Last) 88 Phillip Allen Leslie Servis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Romona K. Roach - Daughter 13695 Lexington Drive, Mount Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Washington National Cemetery 11/23 Suitland, Maryland 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Subdurel hometome Examiner Due to (or as a consequence of): Examine cangestive heort certificata be executed physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 80 980 P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did fobacco use contribute to the cause of death? 94 1 Yee 2 No 3 Probably 4 Unknown 2 Division of Vital Records. by should b 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? has page 20 No 1 Yes 1 ☐ Yes 2 ☐ No certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) To 1 Yas 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 95 13005461 amo 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Dennis Winters, M.D. 198 Thomas Johnson Drive - #6 Frederick, Maryland 31. Data filed (Month, Day, Year) 32. Registrar's Sign State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month **Physician** November 6:40 Pm Velma Purdum /Medical 4a Facility Nama (II not institution, give street and number), Pleasant view Nursing home 4101 old National pike 4b. City, Town, or Location of Death 4c. County of Death Examiner Airy Carroll If Under 24 Hrs. If Under 1 Yaer 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Funeral Days Months Hours 1□M 2XF Yrs Nov. 16, 214-48-6795 81 Director Maryland Usual Rasidence of Dacedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at 1 Tyes 2 No Director Montgomery Maryland Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 23730 Stringtown Road 20871 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Yeer or Detes: 14. Rece - Amaricen Indian, Black, Whita, atc. 11 Merital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours after 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry illed within 7 Hygiene. Elamentery/Secondary (0-12) Coilege (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heelth and Mental Hygiene Important: if frem 27 is marked other tha eny injury or other traumatic event, that DAGE. 10 Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Meidan Sumama) 8 William Lanning Janie Adelle Riggs 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 23726 Stringtown Road, James J. Purdum - Son Clarksburg, Maryland
Data 20c. Location - City or Town, Stata 20a. Method of Disposition 20b. Place of Disposition (Neme of cematary, cramatory or other place) Data 1 XBurial 2 Cremetion 3 Removal from Stata Clarksburg Methodist Cemetery 11/17 Clarksburg, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funerel Sarvice Licensee 22. Name and Addrass of Facility Olin L. Molesworth P.A., Funeral Home olesu 26401 Ridge Road, Damascus, Maryland 20872-0117 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximeta Interval Batween Onset and Death **Physician** /Medical tmmediata Cause (Finel diseese or condition rasulting in death) proportio Examiner Due to (or as a consequence of): Examiner mente physician and the burial-transit The lew requires that the death certificate be executed Sequantially list conditions, if any, taading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? cerebovar alon acceded 1 Yes 2 No 3 Probably 4 Unknown 2 signed bed be 2 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen 1□ Yes &□ No 1 Yas 2 No certificate or Attending Physician: 25. Was cesa referred to medicel axaminar?

1 Yes 2 No Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? After 1 Netural 2 Accident 5 Pending Invastigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicida 6 Could not be determined 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical 29e. Cartifier

State Registrar (Check only one)

29b. Signeture and title of certified

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Kordon

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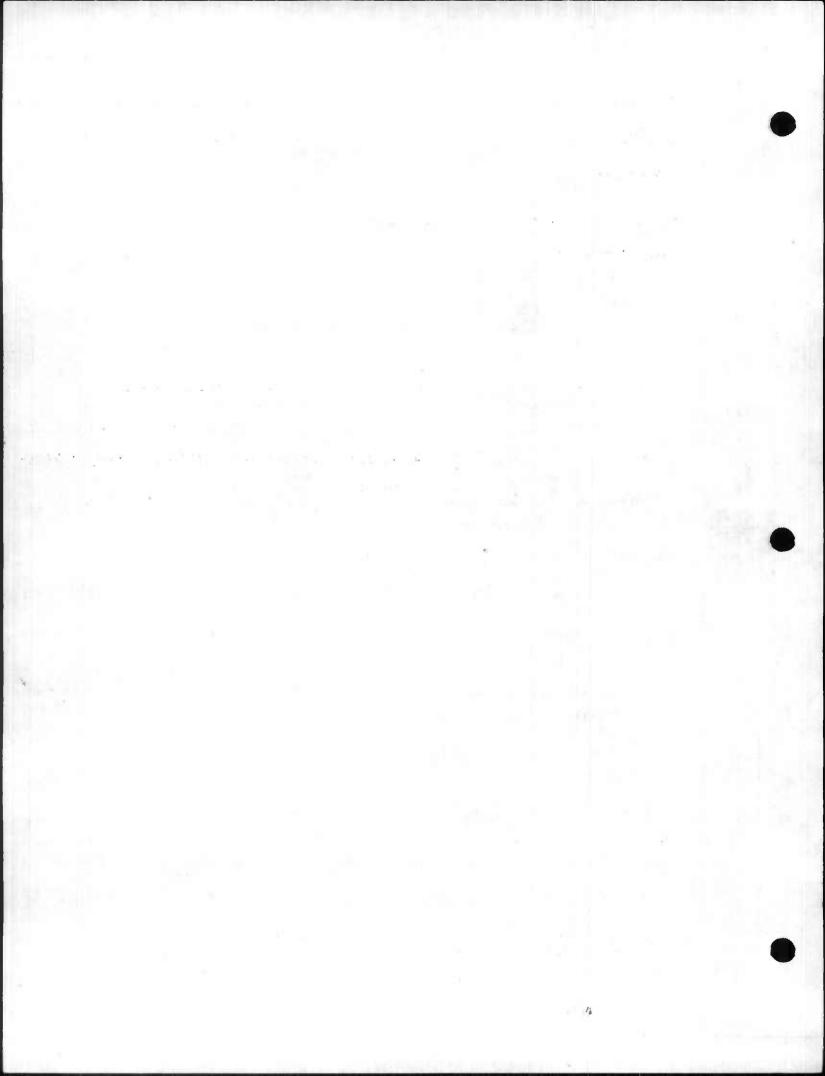
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29c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

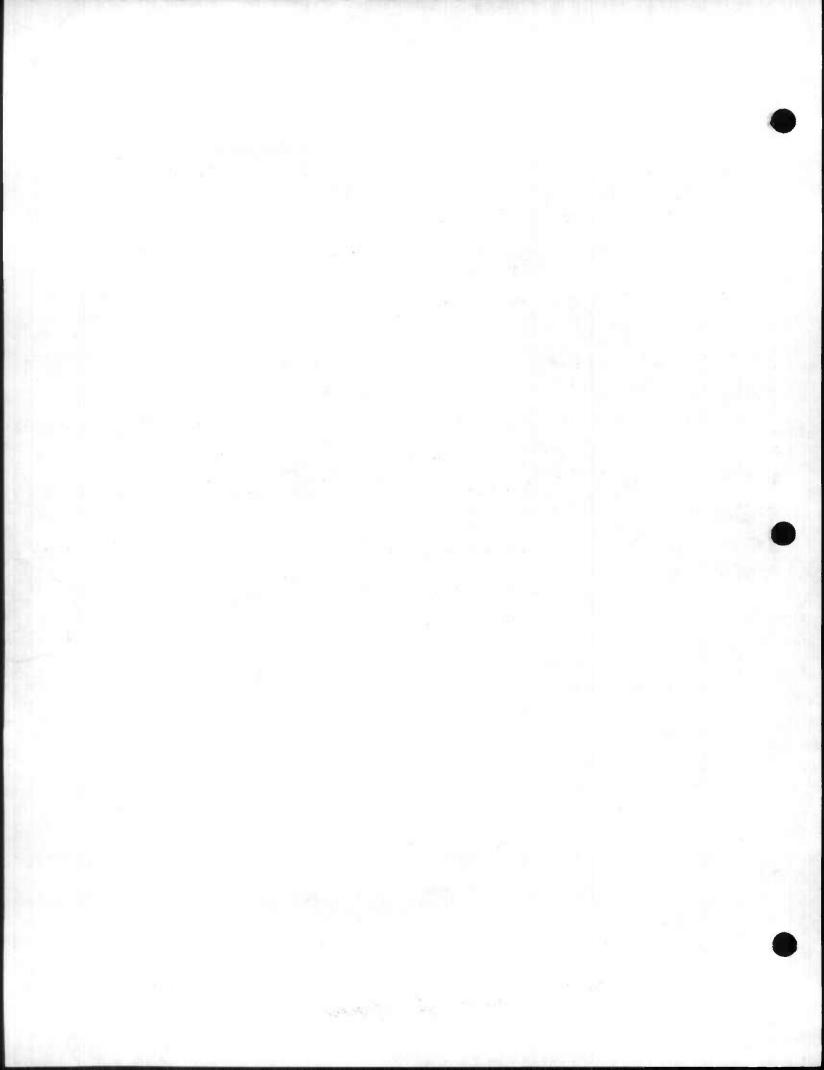
Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Elizabeth M. Powell 17, 1999 2330 P November /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Cecil 5. Social Sacurity Number If Under 1 Yeer If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 6. Data of Birth (Month, Dey, Year) **Funeral** 1 □ M 2 🕅 F Months Days Hours 74 Yrs. Director 194 20 7140 September 9, 1925 Pennsylvania Usuel Rasidance of Decedant with the Merylend 10a. Steta 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f ehow traumstic event, the Medical Examiner must be notified at 1 Yas 2 XNo Director Pennsylvania Chester Unionville 10e. Street and Number 10f. Zio Coda 10g. Citizen of What Country? P.O. Box 306 Walwasset Street 19375 United States deeth v Funeral 12. Wes Decedent Ever In U.S. Armed Forcas? 1 ☐ Yas ≥ 2 No If Yas, Giva Yeer or Datas: 14. Rece - American Indien. Black, Whita, atc. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritai Status permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or her any injury or other traumatic event, the Medical Examines 1 Navar Married 2 XMarried 3altimore, Maryland 21215-0020 White 1 Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiamentary/Secondary (0-12) Coilega (1-4or 5+) Homemaker In her own home 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Thomas Mitchell Marjorie Jackson 0 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Eugene S. Powell/Husband P.O. Box 306 Unionville, PA 19375 20b. Place of Disposition (Name of cemetary, crametory or other piece) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ABurial 2 Cramation 3 Ramoval from Steta 11/22/99 Unionville, PA 4 Donation 5 Othar (Specify) Unionville Cemetery 21. Signature of Funerel Service Licensee 22. Name end Addrass of Fecility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, MD 21921 امد 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Deeth MM **Physician** /Medical Immediata Cause (Finai disaase or condition rasulting in deeth) **Examiner** Examiner burial-transit Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated events resulting in deeth) Last and Dua to (or as a consequence of): P.O. Box 68760, signed by the attending physiclan Physician/Medical 94 Dua to (or es a consequence of): 98 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Onknown 1 ☐ Yas 2 ☐ No 3 ☐ Probably Records, þ 8 24b. Wera autopsy findings svallabia prior to page 2 should Completed 24e. Wes en eutopsy performed? peen completion of cause of death? The lew certificate hes 1 ☐ Yes 2□ No Division of Vital 25. Was case refarred to medical axaminer? Be 26. Piaca of Daath (Check only ona) Othar: 20 No 2 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yas this 27. Manpar of Death 28c. Injury et Work? 28a. Deta of injury (Month, Day Year) 28b. Time of 26d. Dascribe how Injury occurred Certification: To the Hospital or Attanding Is within 24 hours effer death.
To the Funeral Director: After 1 Netural 2 Accident 5 Panding invastigation 1 ☐ Yas 2 ☐ No filled in by the 3 Sulcida 6 Could not be datarminad 26f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 ☐ Homicide edicai 29a, Cartifier 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, date end piece, end due to the cause(s) and mannar es stated. 2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and title of cent 29c. Licansa number 29d. Date signed (Month, Dey, Year) 12 30. Nema and addrass of person who complated cause of death (itam 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Yaar **Physician** Rhianna Justine Ritter 11 19 1999 0737 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot ff Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Deys Hours Min 1 M 2 X F Yrs. Director none 6 11/19/99 MD Usual Rasidance of Decedent works 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits rai', or items 23a or 28a-f show 1 Yas 2 No Director Caroline Ridgely 10g. Citizan of What Country? 10e. Street and Numbe 10f. Zip Code 11876 Holly Plain Drive 21660 U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. 72 hours after 1 Nevar Marriad 2 ☐ Married 21215-0020 natural, or 1 ☐ Yas 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hr. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "neture any Injury or other traumatic event, the Medical Pages. Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) n/a n/a n/a altimore, Maryland 17. Father's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Robert John Ritter Sr. Robyn Arlene Alder 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Robyn Arlene Alder/mother 11876 Holly Plain Drive, Ridgely, MD 21660 20b. Place of Disposition (Nama of cametery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 ☐ Burlal 2X Cramation 3 ☐ Removal from Stata 11/24 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 22. Nama and Addrass of Facility
Moore Funeral Home, P.A. wood 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Batwaan Onset and Death **Physician** fmmediata Causa (Final cardiorespiratory arrest diseasa or condition rasulting in deeth) Examiner Due to (or es e consequenca of): Physician/Medical Examiner b intrauterine asphyxia that the death certificate be executed buriel-transit Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Ceusa (Disease or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of) 68760 meconium aspiration the Dua to (or as a consequence of) 88 Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should be det two true knots in umbilical cord Division of Vital Records. þ Hospital or Attending Physician: The law requires Completed 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? page 2 1 ☐ Yas 2 🖾 No 1 Tas 2 X No certificate funeral director, 25. Wes casa refarred to medical Be 26. Pleca of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) edical Certification: To 1 Yas 22 No 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 1 Natural 5 Pending aftar death. 1 Yas 2 No 2 Accident investigation n/a n/a n/a 3 ☐ Suicida 6 Could not be detarmined 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicida n/a n/a 24 hours a 29a. Cartifiar 1 🔀 Certifying Physicisn: To tha best of my knowledge, daeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steled. within 2 To the å 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signad (Month, Day, Year) tayette Engetions M.D. 041160 Nov. 1999 30. Nema and addrass of person who completed cause of daath (Itam 23a) (Type, Print) Favette Engstrom, M.D., 8579 Commerce Drive, Easton, Maryland 21601 State

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth Day Month Year **Physician** Viola Nov. 24, 1999 0316 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner The Memorial Hospital Talbot Easton If Under 1 Year | If Under 24 Hrs 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 M 2 XF Months 141-28-9015 92 Director Dec 07 1906 New York Usuel Residence of Deceden the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be 420 Colonial Drive 21629 U.S.A. Funeral tharms 2 14. Raca - Amarican Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. r than "natural", or than filed within 72 hours after 1 Yes 2 No 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 homemaker own home 04 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surneme) Be Pages 1 and 2 should be nent of Health and Mental William Alst Barberie Frances Tinsley Barberie 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) or other tr Judith Proctor/ daughter 1811 N. Kenmore Street, Arlington, VA 22207 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 IN Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chester, Maryland Chesapeake Cremation Cn 11/24 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Fleegle & Helfenbein Funeral Home, P.O. Box 160 Greensboro, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** ACUTE MYOCARDIAL NEARCTION /Medical Immediate Cause (Finel disease or condition rasulting in death) Examiner Examiner NEUMONIA sician and burial-transit The law requires that the deeth certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of): physician s the burial Box 68760. **Physician/Medical** thet initieted events resulting in death) Last Due to (or as a consequence of) USB BS [P.O. Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed? should Completed pege 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No After this funeral 27. Menner of Death 28a. Dete of fnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Division 1 Netural 1 ☐ Yes 2 ☐ No within 24 hours after deeth. To the Funeral Director: A 2 Accident the 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

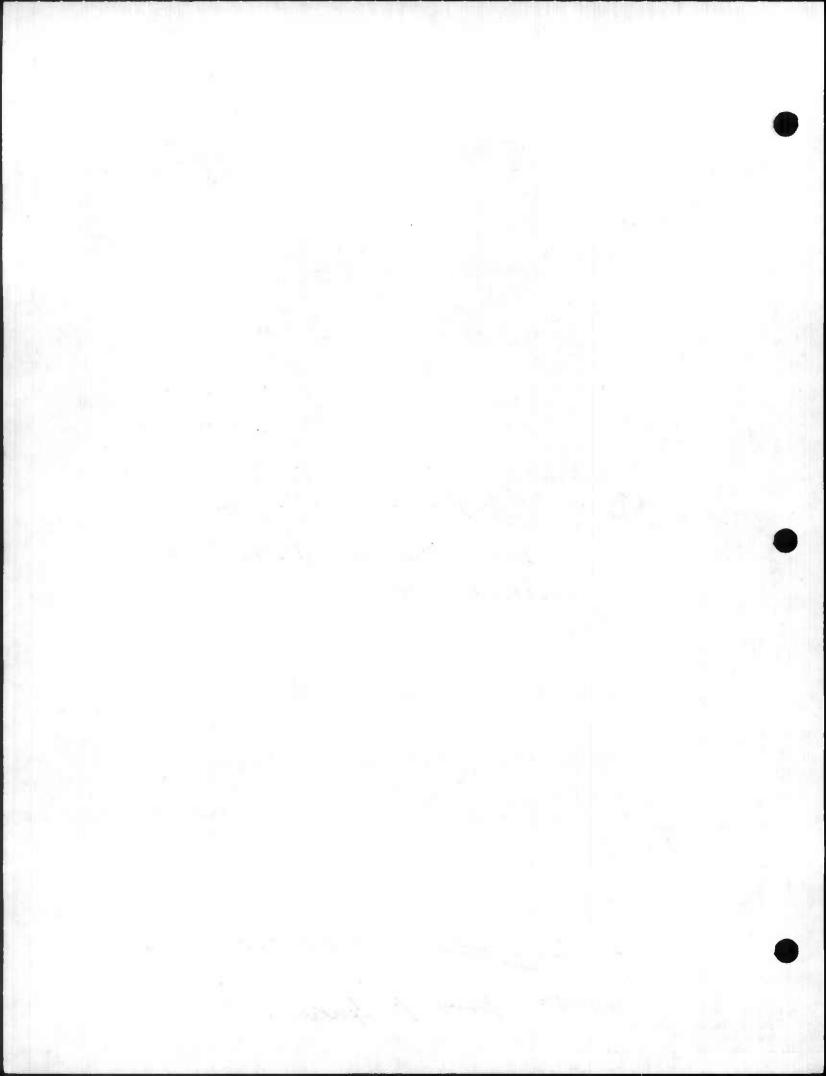
[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) To the 29c. License number 29b. Signature and title of confine 29d. Date signed (Month, Day, Year) 0053815 112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Korah Pulimood 510 S. 5th Street, Denton, Maryland 21629 32. Registrar's Signature State

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Registrar

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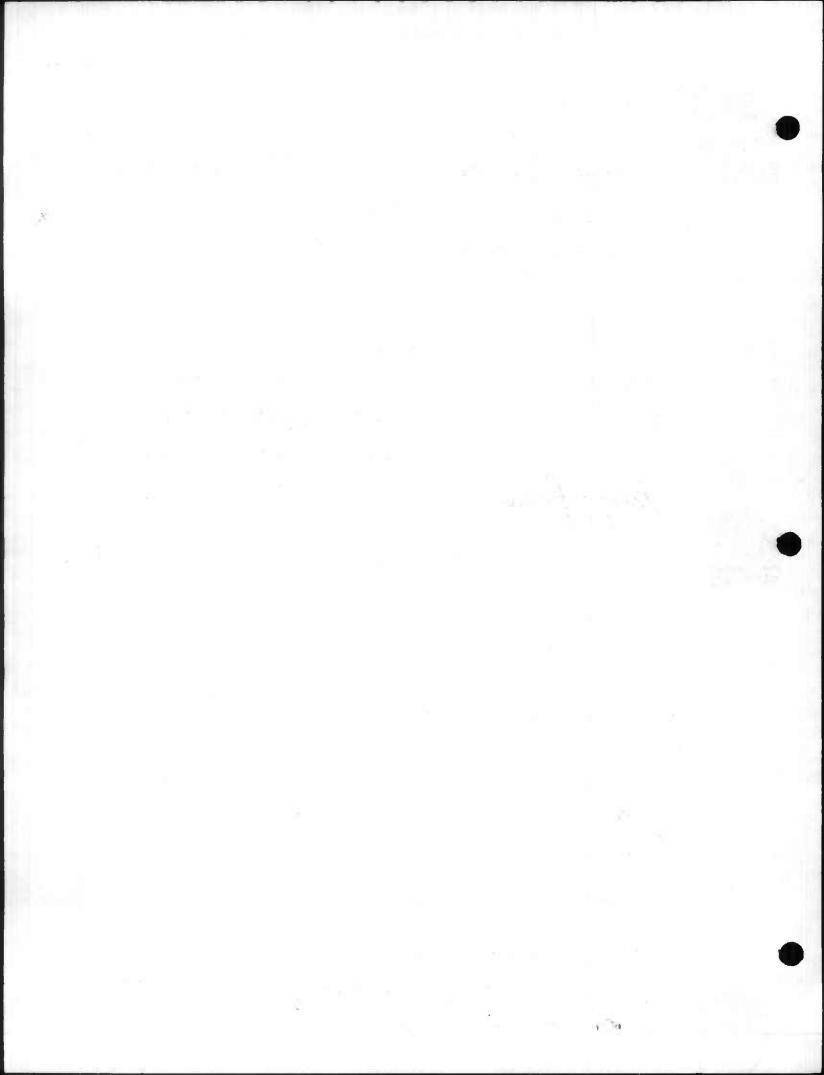
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** NOV. 13 Day 10:50am NORA **JESSICA** REVOIR 1999 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death FREDERICK Examiner FREDERICK RETIREMENT CENTER HOMEWOOD 5. Sociel Security Number If Under 1 Year | if Under 24 Hrs. 8. Data of Birth JAN 1. 190 6 9. Birthplaca (Stete or Foreign Country) ENGLAND 7. Age (In yrs. last birthdey) Funeral Days Hours 1□M 21 F 93 213-74-0276 Yrs. Director Usual Residenca of Decedent 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show FREDERICK CLARKSBURG 1 ☐ Yes 2 XNo Director MD. 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code ò 20871 U.S.A. 2196 SUGARLOAF PARK VIEW LANE Herne 23a death Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11 Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural". Any Injury or other traumatic event. 1 □ Naver Married 2 □ Married 1 ☐ Yes 2 No Specify: WHITE by 3 Widowed 4 □ Divorcad Completed 15. Decedent's Education 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry (Specify only highest grede complated) Elementery/Secondery (0-12) 1 2 TH College (1-4or 5+) HOME HOUSEWIFE 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Melden Sumeme)
EUNICE ESSEX Be **JESSY** SWAIN 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
2196 KSBGRCOAF PARKSTEW LANE CLIFFORD G. REVOIR 20b. Placa of Disposition (Neme of cametery, cremetory or other p 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State METRO CREMATORY NOV. 15,1999 BALT. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility
GARY L. ROLLINS FUNERAL HOME nund 110 WEST SOUTH ST. FREDERICK, 23a. Pert1. Enter the disease, or shock, or heart allure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, only one ceuse on each lina. Approximete Interval Batween Onset end Deeth **Physician** /Medical Immediate Cause (Final neumonia disease or condition resulting in deeth) Examiner Due to (or es e consequence ot): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Due to (or es e consequence of): physician s the burial P.O. Box 68760, Due to (or as a consequance of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be datac 1 Yes 2 No 3 Probably 4 Unknown HIATAL HERNIAWITH GERD Division of Vital Records. Be Completed by 24a. Was en autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? DIASTOCIC DYSFUNCTION page 2 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) 1 Yes 2 No Hospitai: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a, Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29b. Signeture and title of cartifian 29c. License number 29d. Date signed (Month, Day, Year) 46075 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 170 Thomas Johnson Dr. #100 Frederick MD. 21702. 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev **Physician** November20 1999 Edna T. Robinson 300 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Union Hospital Elkton Cecil If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□ M X□ F Yrs Director 218-32-4686 87 May 26, 1912 West Virginia Usuel Residence of Decedent with the Merylend 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or items 23e or 28a-f sho traumatic event, the Medical Examiner must be notified at Maryland Cecil Elkton 1 X Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 15 White Hall Circle 21921 United States death Funeral 12. Wes Decadent Ever in U,S Armed Forces? 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or ther any Injury or other traumetic event, the Medical Event 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Electrical Motor Elementary/Secondery (0-12) College (1-4or 5+) assembler Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) George Bennett Anne Smith 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 640 Old Baltimore Pike, Newark, DE George A. Robinson/Son 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Cherry Hill Methodist Cem. 11/23/99 Cherry Hill, MD 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, Maryland 21921 to be Jan 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel aute collect wfact disease or condition resulting in death) Examiner Due to (or es e consequence of): Condiac are the Due to (or es e consequence of): sician end burial-transit Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Antenstralotte vosular difer physician es the burial P.O. Box 68760. Physician/Medical atten Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Did tobecco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 8 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Was an eutopsy performed? Completed pege 2 hes 1 ☐ Yes 2 ☐ No certificate Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No 1 Nopatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 2 ER/Outpatient 3 DOA After this 27. Magner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Attending 1 Naturel 2 Accident 5 Pending Investigation death. To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office bullding, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner as steted.

Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29a. Certifier Medical completely (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number For ceril Han MD 11/23/ 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Prin for Md main St. 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature State Registrar NOV 23 1999

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 17,1999 Joan Stephanie Ross November 3:30AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center Laplata Charles If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** 1□ M 2⊠ F Months Days Yrs. September 3, 1946 Washington, D.C. **Director** 578-60-5217 Usual Residence of Deceden 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f short must be notified at 1 Yes 2 No Directo Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 Bowie Road 20662 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineering Technician United States Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) 86 permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked or Steve Mamakos Opal Combs 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Ross/Husband 8100 Bowie Road, Nanjemoy, Maryland 20662 20b. Place of Disposition (Name of cemetery, crematory or other place) November 19, 20c. Location - City or Town, State 1999 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licensea 4270 Hawthorne Road, Indian Head, Maryland 20640 M00668 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heet dilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel METASTATIC LUNG CARCINOMA disaasa or condition resulting in death) **Examiner** Due to (or es e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Disease or injury that Initiated events resulting In death) Last Due to (or es a consequence of): Physician/Medical Dua to (or as a consequence of) 98 use signed by the elid be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause ot death? Completed 24a. Was an autopsy pege 2 s certificate has 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 npatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. edical 29a, Certifier

The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital

altimore,

State Registrar

Kevin Lee,MD 7C Post Office Road,Maryland 20002 Center 31. Date filed (Month, Day, Year)

NOV 1 9 1999

29b. Signature and title of certifier

32. Registrar's Signature Zener

My)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

outse

29c. License number

D-054804

29d. Date signed (Month, Day, Year)

or to a tack about 99-6762-005 UNK 99-270 DDG STEVEN R. SOMERS

Funeral

Director

28s-f show

Directo

Funerai

Completed by

Be

r than "natural", or items 23a or 28a-f al the Medical Exprises must be notified

the Maryland

death

filed within 72 hours after

Hygiene.

Pages 1 and 2 should be nent of Health and Mental int: If item 27 le merked o

21215-0020

Baltimore, Maryland

Amended Item 16a, per F.D., 11/16/99, Carroll County, wjl Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	1. Decedent'e Nema (First, N	fiddle, Last)	-
Physician /Medical	Steven Ri	chard So	omers
Examiner	4a Facility Name (If not instit 12000 BLOCK		*

2. Dete of Death Month NOVEMBER 11, 1999 0415 AM

4b. City. Town, or Location of Death 4c. County of Death OWINGS MILLS BALTIMORE Birthplace (State or Foreign Country) If Under 24 Hrs. 6. Sex If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) Days Hours 12 M 2 F 214-46-9891 52 Dec 14,1946 Pennsylvania **Usual Residence of Decedent** 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 West Meadow Road 21225 USA

12. Was Decedent Ever in U,S. Armed Forces? 1 [2] Yes 2 □ No If Yes, Give Viet 11. Maritel Status 1 Never Married 2 Married Viet 3 ☐ Widowed 4 🖾 Divorced Year or Detes Nam

 Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yes 2 No Specify:

14. Rece - American Indian, Black, Whita, etc. White Specify:

15. Decedent's Education (Specify only highast greda completed) Elementery/Secondary (0-12) 12 College (1-4or 5+)

1 Buriel 2 □ Cremetion 3 □ Removel from Stete

16a. Decedent's Usual Occupation Automotive
(Give kind of work done during most of working
life. DO NOT use retired) Services Supervisor Services 18. Mother's Neme (First, Middle, Maiden Sumame)

16b. Kind of Business/Industry Springfield State Hospital

17. Father's Name (First, Middle, Last) Samuel Richard Somers

> 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 806 Houcksville Rd, Hampstead, MD 21074

Thelma Singer

19a. Informent's Neme/Reletionship (Type, Print) Thelma Nusbaum, mother 20e. Method of Disposition

4 ☐ Donetion 5 ☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, cremetory or other piece) Garrison Forest Vet Cem

11/17 Owings Mills, MD

20c. Location - City or Town, Stete

21. Signeture of Funerel Sarvice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feilure. List only one cause on each line.

22. Nama end Addrass of Facility Eline Funeral Home 934 South Main St, Hampstead, Md 21074

Physician /Medical Examiner

burial-trar

the th

US0 85

Physician/Medical

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Be Completed

Certification: To

Medical

t or Attending Physician: The law requires that the death certificate be executed effor death.

Director: After this certificate hes been signed by the attending physician and

should be d

page 2

funeral

completely filled in by

within 24 hours of To the Funeral C Hospital

\$

Box 68760,

P.O.

Division of Vital Records.

Department of Important: If any Injury or

MULTIPLE INJURIES

Due to (or es a consequence of)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Finel

diseese or condition resulting in deeth)

Due to (or es e consequence of):

Due to (or es a consequence of)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death?

Approximeta Interval Between Onset and Death

XXYes

1XXYes 2 No

25. Wes case referred to medical examiner? 1XXes 2 No

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence SQOther (Specify) 28d. Describe how injury occurred

27. Menner of Deeth

5 Pending investigation

28b. Time of 0235

in and accide

2000 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

after and title of dertifier

29c. License number O.C.M.E.

29d. Data signed (Month, Day, Year) NOVEMBER 11, 1999

and address of person who completed veruse of death (Item 23a) (Type, Print) Laron Locke M.D.

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

32. Registrer's Signeture

DHMH 16 Ray 6/95

ORIGINAL

29a, Certifi 29b. Std

1 Neturel 2 X ccident 3 ☐ Suicide 4 Homicide

6 Could not be determined

11/99

28a. Dete of Injury (Month, Day Year) Plece of Injury - At home, ferm, street building, etc. (Specify)

factory, office

CE

28c. Injury at Work? 1 Yes 2 No

brive

28f. Location (Street and Number or Rural Route Number City or Town, State)

2XXMedical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

from 5 Grands

9991 8 J VOV

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Dacadant's Neme (First, Middla, Last) 2. Data of Daeth 3. Time of Daeth Month **Physician** Ronald Bernard Stauffer 5:10pm November 15, 1999 /Medicai 4a. Facility Nema (If not institution, give straet and numbar) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Westminster Nursing & Convalescent Center Westminster Carroll County 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth Jan. 12, 1935 **Funeral** 9. Birthplaca (State or Foraign 1**∑** M 2□ F Days Hours 213-30-3441 64 Maryland Director Usual Rasidanca of Decedant 10a. State 10b. County 10c. City, Town or Location r items 23a or 28a-f show incr must be nothed at 10d. Insida City Limits Carroll Sykesville Director 1 Yas 2 No the ! 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 503 Piney Run Court 21784 IISA Funeral death 12. Wes Dacedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva 14. Race - Amarican Indian, Black, Whita, atc. Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Pages 1 end 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 "natural", or 6 1 Yas 2 No Specify: White þ 3 Widowed 4 Divorcad Yaar or Dates: Completed other traumatic evant, the Medical 15. Dacedant's Education (Specify only highest grada completed) 16a. Dacedent's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) Il Hygiene. Collaga (1-4or 5+) Elamentary/Sacondary (0-12) Salesman Engineering 17. Fethar's Nama (First, Middla, Last) Be 18. Mothar's Name (First, Middla, Malden Sumama) if Health and Menta John Bernard Stauffer Audrey Ott 2 19e. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Streat end Number or Rural Route Numbar, City or Town, Stata, Zip Code) Mrs. Barbara S. Stauffer (Wife) 503 Piney Run Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, State Department of F Important: If ite any injury or of once. ob. Place of Librory Crametory or other place)
All County Cremation Serv. 11/17 1 ☐ Burial 2XXX remation 3 ☐ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensaa 22. Nama and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that count of the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on uncolline. Approximata Intarval Between Onset and Death **Physician** Immadiata Causa (Final diseesa or condition rasulting in daath) /Medicai Examiner Dua to (a) es a consaquence of): Examiner The lew requires that the death certificate be executed the buriel-tran Sequantially list conditions, if any, leading to immediata causa. Enter Undarlying Causa (Disaasa or Injury Due to (or as a consequance of): Division of Vital Records, P.O. Box 68760, the attending physicien hed for use as the burie Physician/Medical thet initiated events rasulting in daath) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. deteched 23b. Did tobacco use contribute to the cause of death? signed by NoYes 2□ No 3 ☐ Probably 4 ☐ Unknown 2 90 Completed 24b. Ware autopsy findings available prior to 24a. Was an autopsy complation of causa of daath? has this certificate 1 Yes 2 PMNo 1 ☐ Yas 2 ☐ No Physician: 25. Was case rafarrad to medical axeminar? Be 26. Placa of Daath (Check only ona) Othar: 4 M Nursing Homa 5 Assidence 6 Othar (Specify) 2 1 ☐ Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Daath Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 or Attending 5 Pending investigation 1 Netural after death. Director: Aft 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours at To the Funeral D 1 Certifying Physician: To tha best of my knowladga, death occurred at the tima, date end plece, end dua to the ceuse(s) end manner as steted.
2 Madical Examiner: On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature 29c. License numbar 29d. Date signad (Month, Day, Year)

State Registrar

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31. Defiled (Month, Dey, Year)

32. Ragistrar's Signatura

B. Sports

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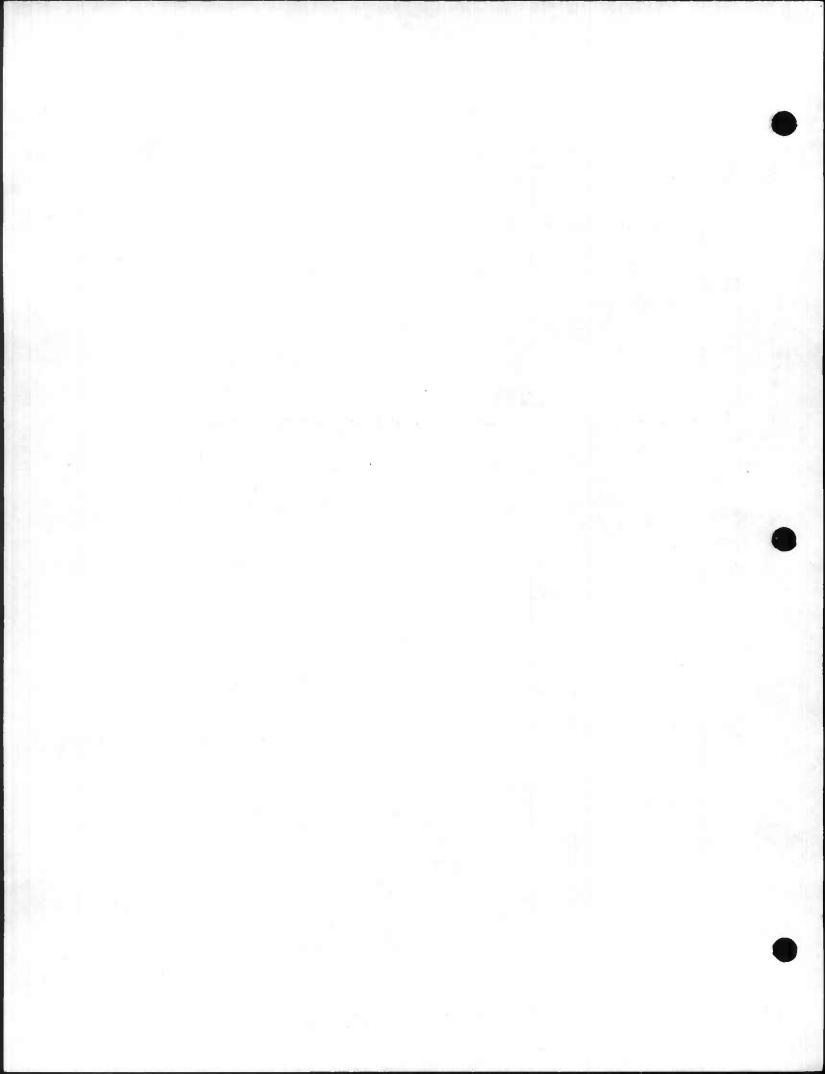
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Registrar

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1999



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State of Maryland / Department of Health and Mental Hygiene 9 3

	Decedent's Nama (First, Middla, Last)		Certificate of		Reg. N	0.	3. Time of Death		
Physician	All	ian Si	mpson		Month D	ay Year			
/Medical Examiner	4a Facility Nama (If not institution, give street			4b. City, Town, or Local		20 1999 c. County of Death	8:44 PM		
	MEMORIAL HOSPITAL			CUMBERLAND		ALLEGANY			
Funeral Director	5. Social Security Number 215-82-5130 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Yaar Months Days	Hours Min.	Date of Birth (Month, Day Year eb 23,	1961 9. Birth	place (Stata or Foreig intro)		
yland	Usual Rasidance of Decedant 10a. Stata 10b. County	10c. City, Town	or Location				10d. Inside City Limit		
oto cto	MD Allega	ny	Cumberlan	d			1 Yas 2 N		
iffer death with the Mai w heme 23s or 28s-fei diner must be notified Funeral Director	10e. Street and Number E. Harrison Stre	et 3rd Floor	10f. Zip Code	21502	10g. C	itizen of What Cou USA	intry?		
by	1 Nevar Married 2 Married 1	/as Decedent Ever in U,S. med Forces? ☐ Yas 2 ☐ No Yas, Give aar or Datas:	13. Was Decedent of H If Yas, specify Cuba 1 Yes 2 No	lispanic Origin? (Specifi an, Mexican, Puerto Ric Specify:	y Yas or No- an, atc.)	14. Race - Amari Black, Whita Specify: wh:	, atc.		
s 1 and 2 should be filed within 72 hours aft if Health and Mental Hygiens in the file m. 7 is marked other than "natural", or other treumatic event, the Medical Exams To Be Completed by F	15. Decedent's Education (Specify only highest grada con Elamentary/Secondary (0-12)	ollega (1-4or 5+)	Decedent's Usual Occup (Giva kind of work dona lifa. DO NOT use ratire	during most of working		Kind of Businass/ir	ndustry		
CO Hard		nc	ne		n/a				
Mental H Mental H arked oth	17. Father's Nema (First, Middla, Last) John Simpson, Jr			18. Mother's Name (First, Middle, Meiden Sumama) Yvonne E (Magruder)					
	19e. Informent's Neme/Ralationship (Type, F Mandy Duckworth	Print) 19b.	Meiling Address (Street ute 1 Box	and Number or Rural F 5B; Wiley	Noute Number, City Ford	or Town, State, Zi	7 6 7		
permit. Pages 1 end Department of Health Important: if item 27 eny Injury or other to bhos.	20a. Method of Disposition 1	val from Stata cemeter		ce)	1/23 Cu al Home				
	23a. Part1. Entar tha disaasa, or complication shock, or haart failura. List only one ca	ns that caused the death. Do n use on each line.					Approximata Intarval Between Onset and Death		
Physician /Medical Examiner	Immediate Causa (Final disaasa or condition resulting in deeth) a	Due to (or as a c	KOTOA	zacois			12 House		
2 2 2		1) 20073	Mallo	25			25 YEALS		
Seath certificate be assected a strending physician and d for use as the burial-transit ICIan/Medical Examiner	Sequentially list conditions, it any, laading to immediate cause. Enter Underlying Cause (Disases or Injury that initiated avants rasulting in death) Last	Due to (or as a c							
e attendir of for use	5								
by the seche	Part II. Other significant conditions contribut	ing to death but not resulting in	tha underlying cause giv	ven in Part I.		No 3□Pro	to the cause of dea obably 4 Unkn		
aw requiras is been sign 2 should be pleted by					24a. Was an aut performed?	a	Vere autopsy finding vailable prior to completion of cause of death?		
rata ha					1 ☐ Yes	20 No 1	☐ Yes 為 No		
certificata rector, par	25. Was casa rafarred to medical axaminer?			26. Place of Deeth (6	Check only one)				
T di	1 XYas 2 No Hospit	a. Deta of Injury 28b. T		4 LI Nursing Homa	5 Residence		tify)		
deat deat ctor: y the	2 Accident invastigation	a. Place of Injury - At homa, far	Yes 2 □ No 281	Location (Street and Number or Rural Routa Number, City or Town, State)					
Propriation of the state of the		building, atc. (Specify) : To the best of my knowledge,	death occurred at the tir	ms, date and place, and			steteri		
within 24 hours after within 24 hours after To the Funeral Director Completaly filled in Director Medical Certification Certific	one) 2 Medical Examiner: C	On the basis of examinetion and manner steted.	/or investigation, in my o	pinion, death occurred	at the tima, data ar	nd piece, and dua	to the cause(s)		
2 2 2 2	29b. Signatura and titla of certifier	206	29c. Licens	e number		ata signed (Month			
_ 3	Det U	FLO	02	51213	NOVE	EMBER 21,	1999		
nus	30. Name and address of person who comple	ted cause of death (Item 234) (Type, Print)		(

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Yes Richard Shearer November 16, 1999 /Medical 11:20 am 4c. County of Death 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland
If Under 24 Hrs. Memorial Hospital Allegany 8. Date of Birth Feb 15, 1929 9. Birthplace (Stele or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Months Hours 15M 20F 213-24-7093 70 Director Usual Residence of Decedent with the Manyland 10a State 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or hams 23s or 28s-f ahor Director 1 Yes 1 No Bedford Bedford 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15522 331 Olympic Road USA Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if frem 27 is marked other than eary injury or other traumed. 12. Wes Decedent Ever in U,S.
Armed Forces?
1.2 Yes 2 No
If Yes, Give yeer or Dates: 1947-50 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: white py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner and Operator Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Shearer Mary (Johnson) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 Olympic Road; Bedford PA 15522 19a. informant's Name/Reletionship (Type, Print) Clara Z. Shearer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Kurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Providence Cemetery 11/19 Centerville, PA 21. Signature of Funeral Service Licenses 22Scarperiff funeral Home P.A. Cumberland, Maryland ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate interval Between Onset and Death 23a. Part1. Enter shock, or he **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner nonth DAGU The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a cons Ma Physician/Medical Due to (or as a consequence of) is certificate has been signed by the e director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by Records. 24b. Were autopsy findings aveilable prior to Be Completed 24a. Wes an autopsy completion of cause of death? this certificate has 181 on 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 2 € Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? After Natural 5 Pending 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A: 2 Accident investigation illied in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wo > 1999 D0054426 November 30. Name and address of person who come se at de (Item 23a) (Type, Print) MAS Memorial Mospital Medical Bldg. 105, 500 Memorial Ave. Cumberland MD Michael D. Zang 31. Dete filed (Month,

DHMH 16 Rav 6/95

State Registrar

213-24-7093

Shearer

Richard

32. Registrer's Signeture

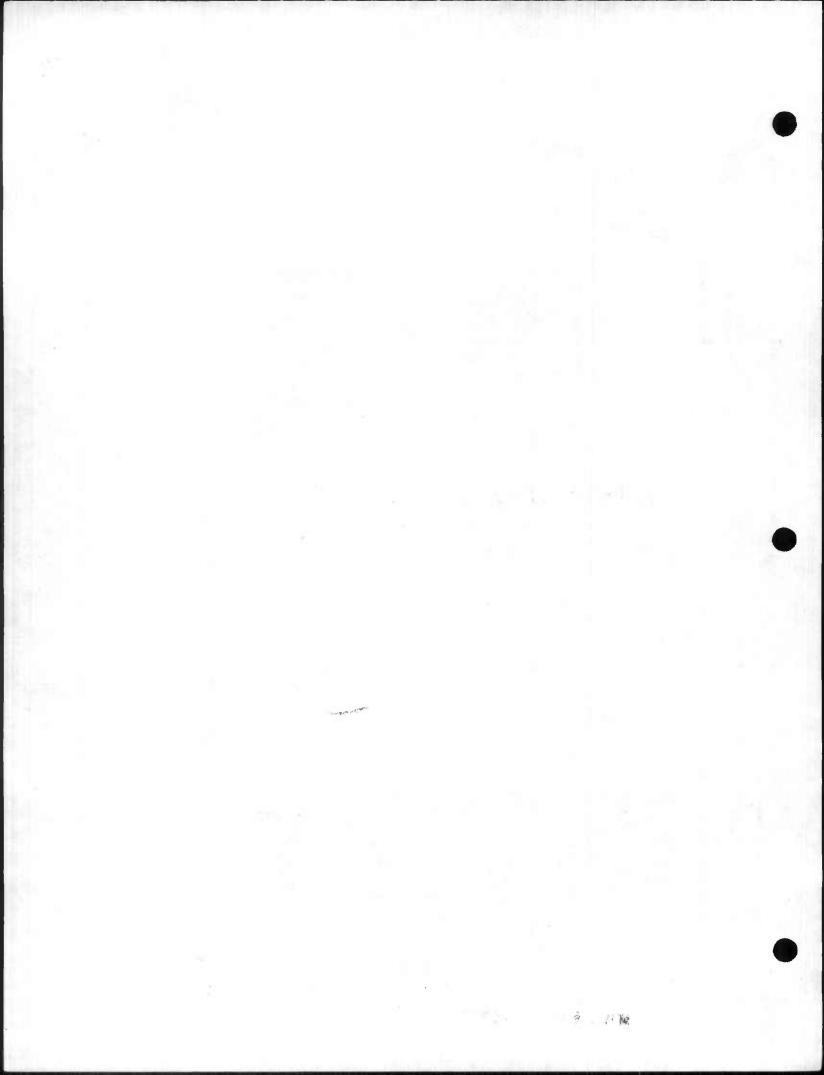
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** William Dayton Skinner 16, 1999 November 10:56 am /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Citizens Nursing Home of Frederick County Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 F 039-09-3006 74 Aug 10, 1925 Director Rhode Island Usuel Residence of Decedent the Marviand 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show Maryland Frederick Frederick 1K Yes 2 □ No Director 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b munt be 1772 Harvest Drive 21702 U.S.A. therms 23a Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No 1944— If Yes, Give Yeer or Detes: 1946 filed within 72 hours after 1 Never Merried 2 Nerried Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Statistician Federal Government 5+ 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic even 88 Charles Skinner Dayton May Mack 19e Informent's Neme/Reletionship (Type, Print)
Mrs Phyllis J. Skinner/Wife 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1772 Harvest Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removel from Stete Department of Important: If any injury or page. Smithsburg Crematory, Nov. 17, 1999 Smithsburg, Maryland 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility
Keeney & Basford P.A. Funeral Home Dra M00255 106 East Church St, Frederick, Maryland 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, abock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel neumonia Bilatera 2 week diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Laat Due to (or es a consequence of): physician s the buria Box 68760, Physician/Medical Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia Records. à 24b. Wera autopsy findings available prior to Be Completed 24a. Wes en autopsy performed? completion of ceuse of death? 1 ☐ Yea 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division After 5 Pending investigation 1 Natural in 24 hours after death.
The Funeral Director: After the funeral to the funeral t 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner ateted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D43091 November 16, 1999 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 801 Tollhouse Avenue, Frederick, Maryland 21701 Saeed A. Zaidi. 32. Régistrer's Signeture 31. Date filed (Month, Dey, Year) State NOV 1 8 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year Physician Robert James Schumm, Jr. 11:40am 99 11 13 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10249 Meadow Ridge Drive Myersville Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** Months 1⊠M 2□ F Director 105-40-4909 49 11 - 20 - 49New York Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location Show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shores. The Medical Examiner must be notified at 1 Yes 2 No Director Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10249 Meadow Ridge Drive 21773 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Merried 2 Married 1 ☐ Yes 2 No 21215-0020 1 ☐ Yes 2 ☑ No Specify: p Specify. white 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Painter construction altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit timent of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be Robert James Schumm, Sr. Dolores Lins 19e. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Schumm / wife 10249 Meadow Ridge Drive, Myersville, MD 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from Stete permit. Page Department of Important: If any Injury or Resthaven Memorial Garden's 11/17 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Ricketts Funeral Home 504 Main St., Myersville, MD ekelle 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ects/ extrasive disease or condition resulting in death) C 7- 6/7 079 Examiner Due to (or es a consequence of): Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest and Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 10 USB Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yee No 3 Probably 4 Unknown signed I Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 No certificate 1 Yes 2 No Division of Vital funeral director, 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Netural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, term, street, tectory, office building, etc. (Specify) illed in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical within 24 hou To the Fune completely fi

State Registrar 29b. Signeture end title of certifier

31. Date tiled (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

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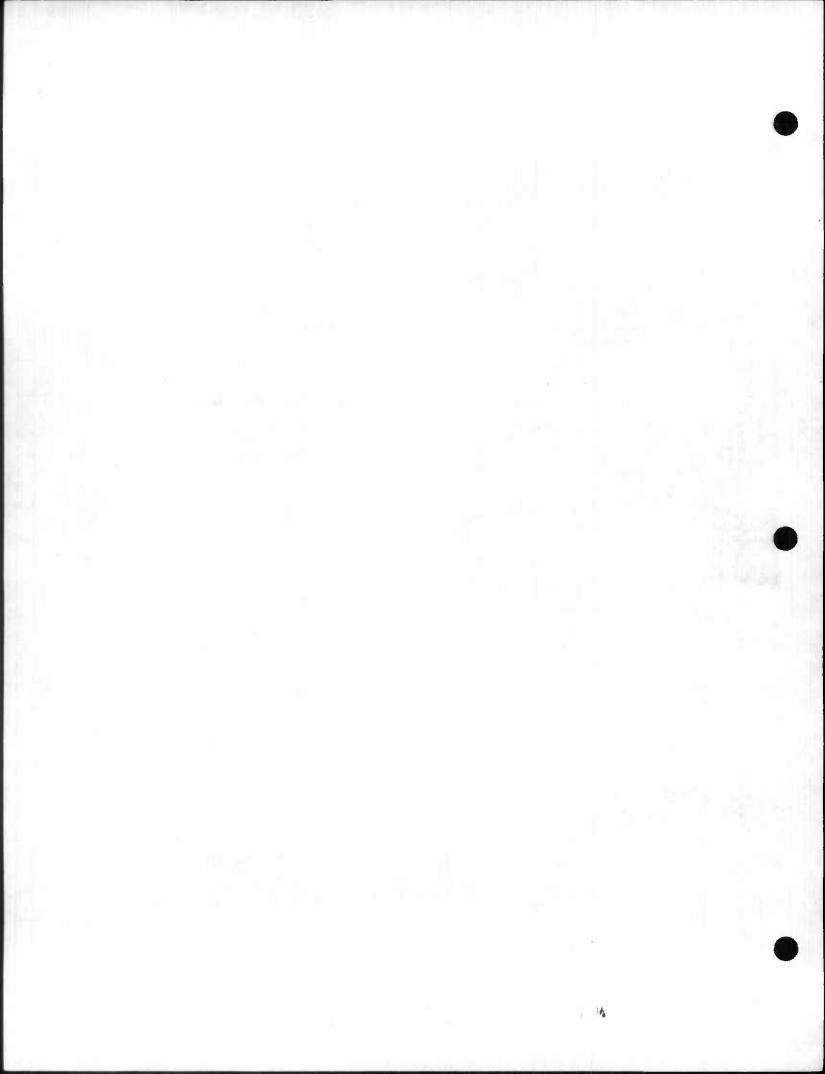
32. Registra s Signature

29c. License number

2

29d. Date signed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 3. Time of Death Day Month Yaar **Physician** Tracy Surber November 11, 1999 5:23 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 8. Dete of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpleca (Stete or Foreign Country)
 VA **Funeral** Days 10 M 2□ F 230-48-3365 62 1937 Director Jan Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County r 28a-f show Montgomery Dickerson 1 N Yas 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be n 20842 6214 Dickerson Road U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 औ No If Yes, Give Year or Detes: al Hygiens.
I other than "natural", or items went, the Medical Examiner. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Merried 2 M Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Elementery/Secondary (0-12) College (1-4or 5+) Maintenance Montgomery College permit. Pages 1 and 2 should be lile.
Department of Health and Mental Hyginthoriant: If Nem 27 is marked other any Injury or other traumented other 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Charles F. Surber Ada K. Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 20842 6214 Dickerson School Rd. Dickerson, Mary K. Surber/spouse 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from Stata 4 □ Donation 5 □ Other (Specify) Elizabeth Cemetery 11/16 Saltville, VA 21. Signature of Funerel Service Licenses 22. Nama and Address of Facility Hilton Funeral Home Box 86 Barnesville, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such es cardiec or respiretory errest shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onset and Deeth **Physician** MYOCARDIAL ISCHEMIA /Medical Immedieta Causa (Final hours disaasa or condition resulting in death) Examiner Due to (or as a consequence of): mouths METASTATIC LUNG CANCET Examine physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 68760 Physician/Medical that initieted events rasulting in death) Last Dua to (or es a consequence of): Box 980 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. Yee 2 No 3 Probably 4 Unknown þ 24b. Wera sutopsy tindings available prior to 24e. Wes an autopsy performed? Completed completion of cause of deeth? certificate hes b 1 ☐ Yes 2 1 No 1 Yes 2 No Division of Vitai or Attending Physician: Be 25. Wes casa refarred to medical axaminer? 26. Place of Deeth (Check only ona) To. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 12 Inpatient 2 ER/Outpatient 3 DOA Shi s funeral 28a. Date of tnjury (Month, Day Year) 27. Manneg of Death 28d. Dascribe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1. Natural 5 Pending i after death.
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In by the fur 1 Yas 2 No investigation 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 24 hours after Funeral Direct Matery filled in b 4 Homicide Hospital Cortifying Physician: To tha best of my knowledge, death occurred at the time, data end place, end due to the cause(s) and mannar as stated.

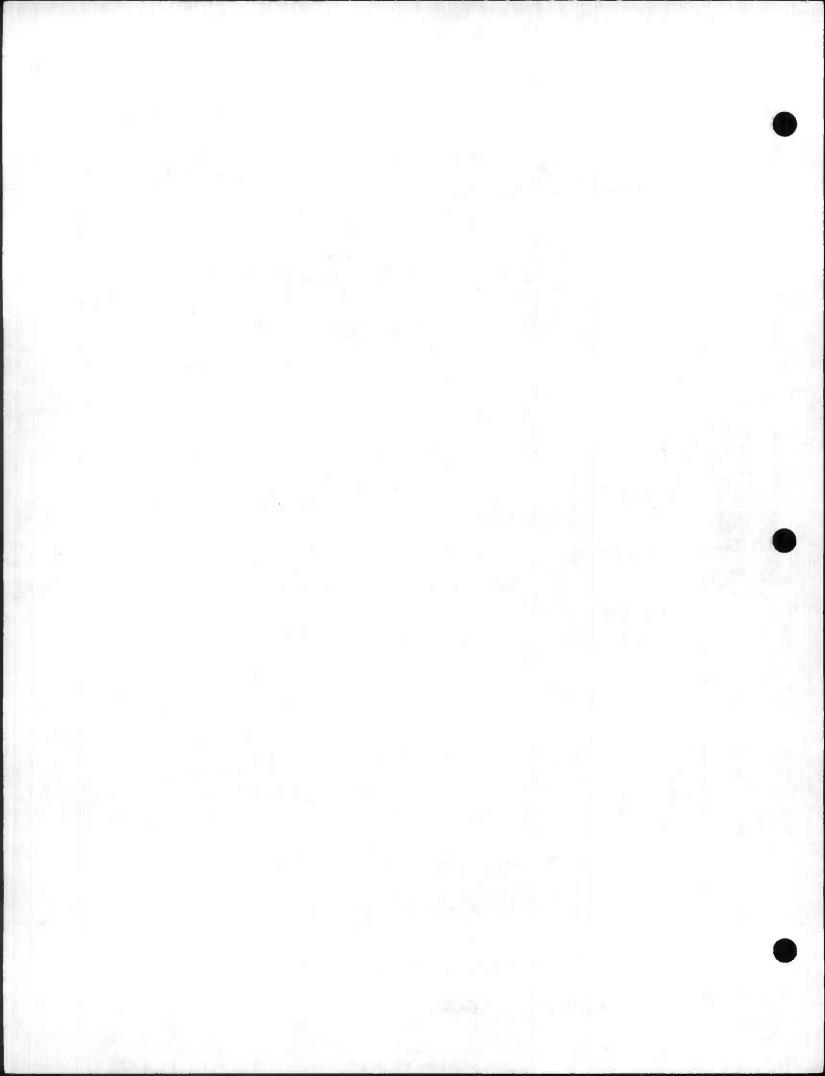
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State Registrar A.Z. HEGAZIMO

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NOV'1 5 1999 Registrat Signature



DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

NOV 2 2 1999

32. Registrer's Signature

111 West High Street, Elkton, Maryland

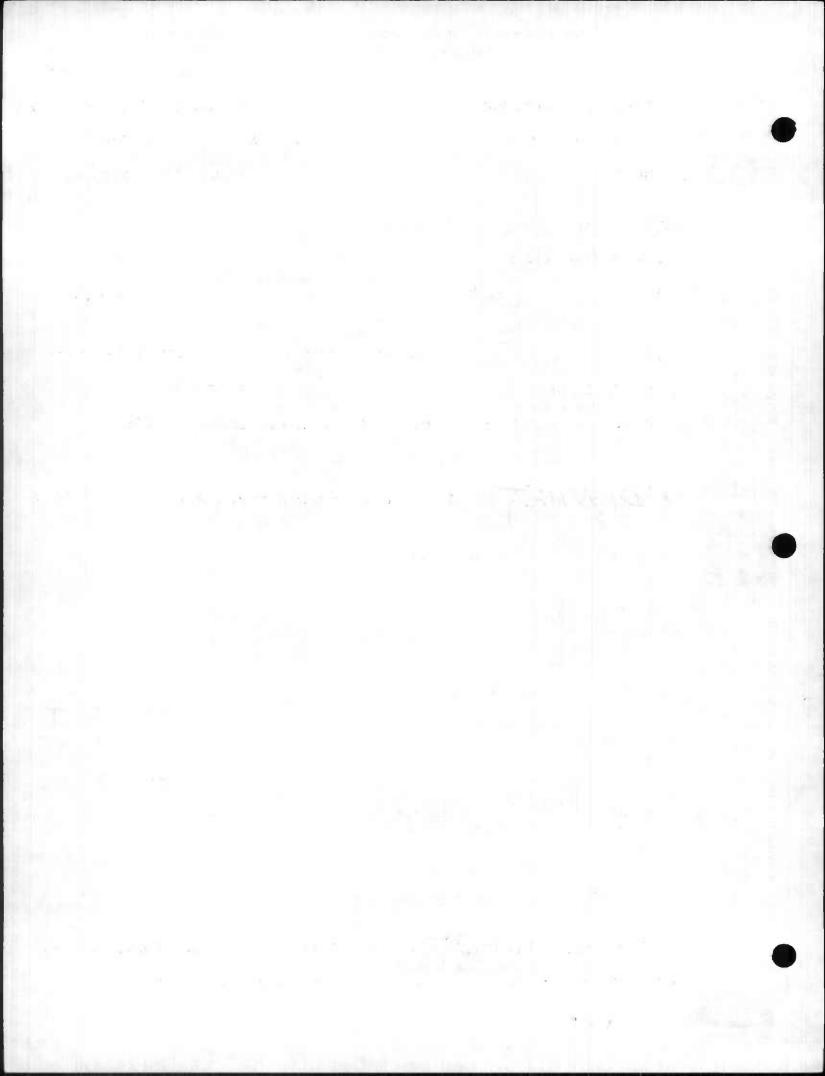
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State of Maryland / Department of Health and Mental Hygiene 9 3776

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	⊢ ≯ ⊢ ŏ		Kerry M. Mallon D28352 NOVEMBER									23,	1999				
			30. Nama and address of person v KRISHAN MATH							, I	LA PL	ATA	, MD	20646			
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth NOVEMBER 14999 Betty Louise Tracey 8:30 AM 4e. Facility Neme (If not institution, give street and number) Saint Joseph Medical 4c. County of Deeth Baltimore 4b. City, Town, or Location of Deeth Center Hours Min. 6. Dete of Birth (Month Day, Year) April 30, 1923 If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 1□ M 201F Deys 213-20-0916 76 Pennsylvania Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Freeland 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21022 Middletown Rd. 21053 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Biack, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 □ Widowed 4 □ Divorcad 16e. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Nema (First, Middle, Last) 16. Mother's Neme (First, Middle, Maidan Surneme) John B. Glick Bertha Copenhaver 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Chilcoat/Daughter 3002 Anderson Rd., White Hall, MD 21161 20b. Pieca of Disposition (Neme of cametery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Nov. 30, 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete Middletown Cemeterv 4 Donatton 5 Other Spacify 1999 Freeland, MD 21. Signature of 22. Name end Address of Fecility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, or he feiture. List only one cause on each line. Approximete Intervai Betw Onset and Deeth CONGESTIVE HEART FAILURE immediate Causa Finel disease or condition resulting in deeth) Due to (or es e consequence of) Sequentielly ilst conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Last Dua to (or as e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown STROKE 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes an autopsy performed? RENAL FAILURE 1 Yas 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menner of Death 26e. Deta of injury (Month, Dey Year) 26b. Time of 28c. Injury et Work? 26d. Describe how injury occurred 5 Pending investigation 1 Naturei

attending physicien and for use as the buriel-transit the deeth certificate be executed P.O. Box 68760, Records, certificate has Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Physician/Medical signed by t p Completed page 2 Be 10 Certification: Medical

2 Accident

3 ☐ Sulcide

29a. Certifier

4 ☐ Homicide

Physician

/Medical

Director

Funeral

ģ

Completed

Be

Examiner

Funeral

Director

8

7 is marked other than "natural", or items 23s or 25a-f show traumstic event, the Medical Examiner must be notified at

pergit. Pages 1 and 2 should be tiled within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other tean "natural", or the any injury or other fraumatic event, the Medical Examines once.

Physician

Examiner

Examiner

Baltimore, Maryland 21215-0020

State

29b. Signeture end tille of certifier

| Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) end menner steted. 29c. License number 37284

1 🕵 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted.

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Dey, Year)

26f. Location (Street end Number or Rural Route Number, City or Town, Stete)

11-27-99

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)
BOON F. LIM, M.D., 7601 OLSER DRIVE, TOWSON. MD 21204

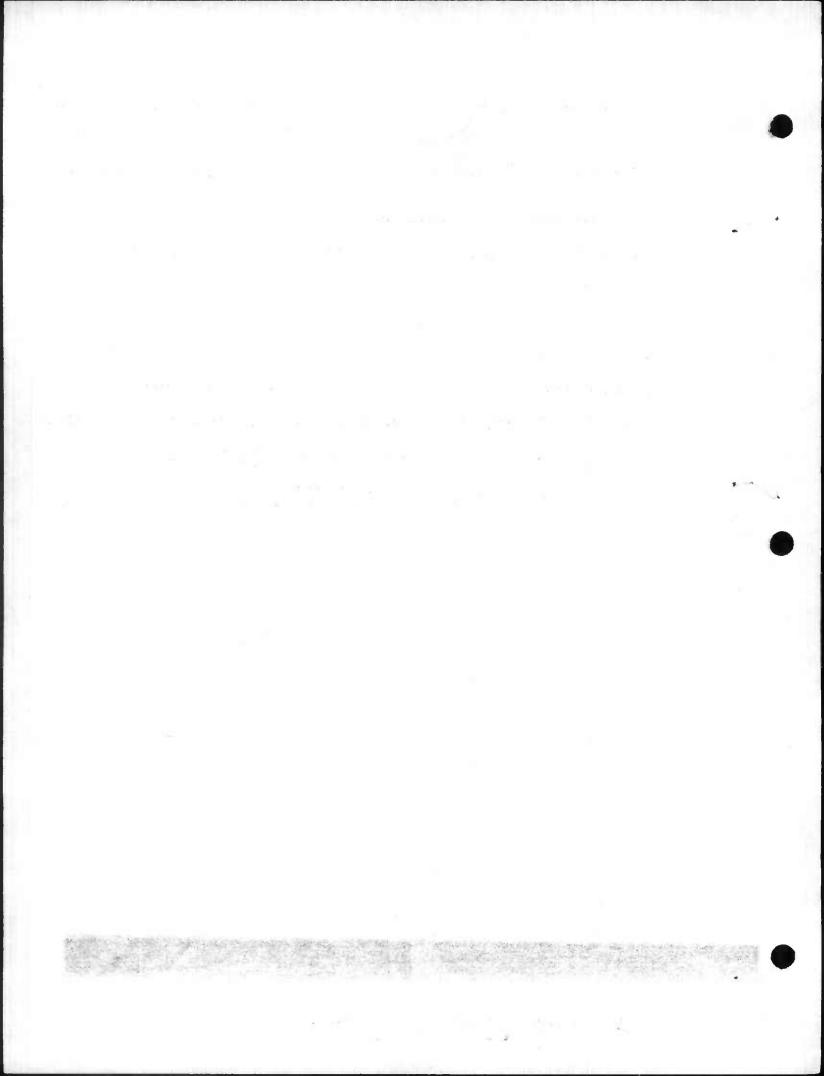
26e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

31. Dete filed (Month, Dey, Year) Registrar

6 Could not be

32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		Reg. No.	9 37	768	
Г	Physician	1. Decedent's Name (First				Mont out			2. Date of Do	18, Day 199		ne of Death	
	/Medical	Geneva		Α.		Twigg	J	4h Cihi Toum as l				08am	
	Examiner	4a Facility Name (If not in Devlin Ma	nor Nu	irsing	Home			4b. City, Town, or t	and		Allega		
ı	Funeral Director	5. Social Security Numbe 214-07-16	36	x □M 2 X F	Age (In yrs. Is 81		If Under 1 Year Months Days	The second secon	8. Date of Bi	rth ey, Year'918	9. Birthplace (St	ate or Foreign	
	w m	Usuel Residence of Dece 10a. State 10b.	County		10c. City	, Town or Lo	cation				10d. Insk	de City Limits	
	Meny He h	MD	Alleg	gany		Cun	berlan	d			1₩	Yes 2□No	
21215-0020	iter death with the Mei r items 23a or 28a-f e iner man be not of Funeral Director	10e. Street and Number 1400 Holl	and St	treet			10f. Zip Code	21502		10g. Citizen of V	What Country?		
	by F.	11. Marital Status 1 Never Married 2 3 Widowed 4 D	Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	BNo	11	Vas Decedent of Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puerting Specify:	pecify Yes or No Rican, etc.)	Blac	e - American India kk, White, etc. white	n,	
	ges 1 and 2 should be filed within 72 hours to Health and Mental Hygiene. If item 27 is marked other than "natural", or other traumatic event, fre Medical Exe To Be Completed by	15. [(Specify on: Elementary/Secondary	15. Decedent's Education (Specify only highest grade completed) y/Secondary (0-12) College (1-4or 5+)				ent's Usual Occu kind of work done DO NOT use retin	pation a during most of wor ad)		16b. Kind of Business/Industry Own Home			
Maryland 2	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any injury or other traumatic event, fra lagge. To Be Compi	17. Father's Name (First, William W		n Tripl	.ett			18. Mother's Nan Flora		msey)	99)		
Mary	nd 2 shoulth and M 27 is mar r traumat	19a. Informant's Name/R Norval Wa	yne Tv	vpe, Print) vigg		19b. Mailin 1400	g Address (Stree Hollan	d Stree	ral Route Numb	erland	State, Zip Code) MD 21	502	
altimore,	Peges 1 a ent of Hex nt: If frem ry or othe	husband 20a. Method of Dispositio 1 Burial 2 Cre 4 Donetion 5 0	mation 3 🗆 F	Removal from Sta	ite Ce	m <i>etery</i> , cren	sition (Neme of netory or other pid	, i	Date		City or Town, Sta		
Baltin	permit. P Depertm Importar any injur	21. Signature of Funeral) A 4 ~	1 28	carper	rans Cer TTFTune: and, Mar	ral Ho			MD	
		23a. Part1. Enter the dis	aase, or complied. List only of	lications that cause on each	sed the death h iine.	10			_		Approx	Imate I Between and Death	
	Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	24	a	Due to (or	as a censed	uence of):	Brain Se	gnobe	me	8	your	
o,	ficete be executed physician end ts the bunel-fransit edical Examiner												
x 68760,	Z 0.0	that initiated events resulting in death) Last		d	Due to (or	as a consequ	uenca of):						
Box	death ce ettendiid for use	Part ii Other eignificent	conditions co	atributing to death	h but not recu	itles in the ur	deriving cause g	iven in Part I	23h Did	I tohacco use co	ntribute to the ce	use of death?	
s, P.O	res that the death or igned by the ettend be deteched for us.	- Control of the cont	John Marie Co.	nditions contributing to death but not resuiting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of de			
Records,	been should								24a. Wa: peri	s an autopsy ormed?	24b. Were auto available p completion of death?	rior to	
- B	0 - 0 =								1 🗆	Yes 2000	1 ☐ Yes	2 No	
Vital	ystclan: The is certificate director, par	25. Wes case referred to examiner?		Hospital:				28. Place of Dea	th (Check only	one)			
o	his aldi	1 ☐ Yes 2 No 27. Menner of Deeth		1 ☐ Inpa		R/Outpatien 28b. Time of	3LJ DOA			idence 6 Oth			
ion	Attending or death. ector: After by the fune		Pending investigation	(Month,	Dey Year)	Injury	M 1	ork?]Yes 2□No		,,			
Division	P450 F		Could not be determined		Injury - At hor etc. (Specify,		eet, factory, office		28f. Location City or To	(Street end Numb own, Stete)	per or Rural Route	Number,	
	To the Hospital or within 24 hours effe To the Funeral Dir. completely filled in Medical Cert				s of examinati			ime, date and place opinion, death occu				use(s)	
		29b. Signature and title	ceptiter /	2			29c. Licer	se number		29d. Date signe	d (Month, Day, Ye	ar)	
	3	1/	n				D36	766		Nov. 18, 1999			
	7,0	30. Name and address of											
	State	Dr. Vik Poc 31. Date filed (Month, De	nai; 9	22 Natio	nal Hi	ghway;	Cumber	land, MD	21502				

Registrar

NOV 1 8 1999

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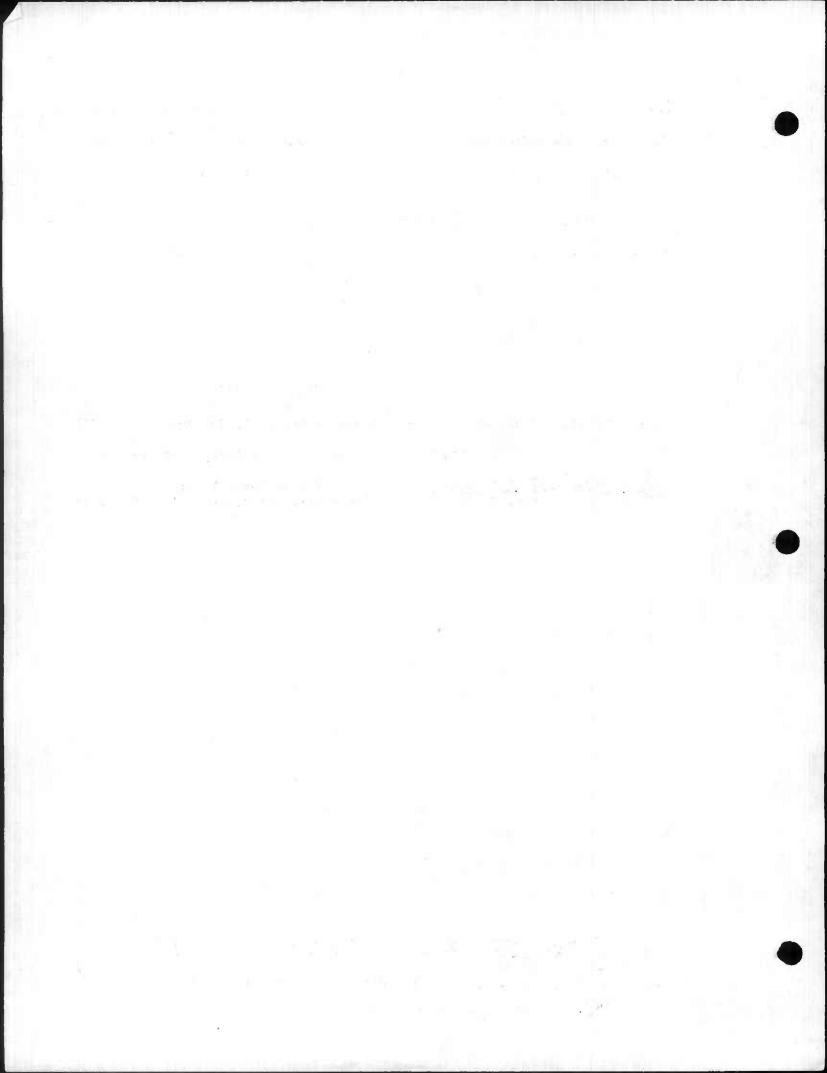
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2 Date of Death 3. Time of Deeth Month **Physician** NORA TRAIL 6:45 PM NOVEMBER 17 1999 /Medical 4e. Fecility Nema (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** FREDERICK HEALTH CARE CENTER FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foraign Country) Funeral 1 M 2 XF Months 99 Director 216-38-0195 January 6 1900 Baltimore MD Usual Rasidence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylas Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is merked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, it a Marical Examinat must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5605 Huntsmoor Road USA Funeral 12. Was Decadent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Bleck, White, atc. 1 ☐ Nevar Married 2 ☐ Marriad altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ XNo Specify: à 3 ☐ Widowed 4 ☐ Divorcad Yaar or Dates: White Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Homemaker Housewife 6 17. Fether's Name (First, Middle, Last) (unk) 18. Mother's Nema (First, Middle, Meiden Surnama) Be 2 Christina Silali 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Steta, Zip Code) Frances L. Hahn, daughter 3860 Shadywood Drive 2A, Jefferson, MD 21755 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel Irom State Lutheran Cemetery 11/20/99 Jefferson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
John T. Williams Funeral Home Barbara A. Williams, Owner 100 Petersville Road, Brunswick, MD 21716 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one ceusa on each tine. Approximete Intervel Between Onset end Death Physician Immedieta Ceuse (Finet diseese or condition resulting in deeth) /Medical **Examiner** Examiner be executed buriel-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Lest Bud Dua to (or es e consaquance of) Box 68760. physician Physician/Medical the Due to (or as a consequence of): USB BS ettending P.O. 1 Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes No 3 Probably 4 Unknown Records, by 24b. Wera autopsy findings aveileble prior to Completed 24a. Wes en autopsy performed? peen complation of cause of death? The law certificete 20 No 1 Yes 1 TYes 2 No Division of Vital 25. Was case raferred to medical examiner? Be 26. Place of Deeth (Chack only one) Other: 45 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yas 2 No Certification: To this To the Hospital or Attending Phywithin 24 hours efter death.
To the Funeral Director: After thi completely filled in by the funeral 27. Mannar of Death 28e. Deta of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, straet, factory, offica building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida Certifying Phyalcian: To the bast of my knowledge, daeth occurred et the time, data and pteca, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end ptace, and due to the ceuse(s) end manner stated. Medical 29a. Certifian (Check only one) 29b. Signature and title of confiler 29c. Licensa number 29d. Dete signed (Month, Dey, Year) FRENERICKIMID 21702 30. Name end edd as a partion who completed cause of death (Item 23e) (Typa, Print) OHNSON, SUITE 202, 172 THOMAS JUHUSEN DIRIVE WILLIAM 31. Deta filed (Month, Day 32. Registrer Signeture State 1999 Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month ETHEL ENDICOTT TERRELL 1999 NOVEMBER 21 1:00pm 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth CHARLES LA PLATA CIVISTA MEDICAL CENTER | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | 9. Birthplace (State of Month) | November 4,1932 | Washington 5. Social Security Number 9. Birthplace (State of Geign 7. Age (In yrs. last birthdey) 6. Sex 1□M 2XF Months 67 Yrs. 578-40-8033 Usual Residence of Decedent 10e. Stete 10b. County 10c, City, Town or Location 10d. fnside City Limits 1 Yes 2 No Charles Port Tobacco 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 20677 6970 Our Place 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 ☐ Married Specify: White 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Receptionist 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) Ethel May Endicott Terrell Walton E. Terrell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 6970 Our Place Port Tobacco, MD 20677 Beverly Grinder/daughter 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2X Cremetion 3 ☐ Removel from State Metropolitan Crematory11/23/99 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetation Funerel Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Finel Chrowic OGMuchin Teavo Due to (or es a consequence of):

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Physician

/Medical

Examiner

Directo

Funeral

by

MD

Funeral

Director

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinet must be notified at ence.

attanding physician and for usa as the burial-transit The law requires that the death certificate be executed signed by the a d be detached f s cartificata has b director, paga 2 s Hospital or Attending Physician: 24 hours aftar death.
Funerel Director: Aftar this cartifica staly filled in by the funeral director, §

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24e. Wes en autopsy performed? Were eutopsy findings aveilable prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Madfcai Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

State Registrar 31. Dete filed (Month, Day, Year) 1999 NOV 23

29b. Signeture end title of certifier

SHARMO 32. Registrer's Signature Leneva

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO souls!

29c. License number

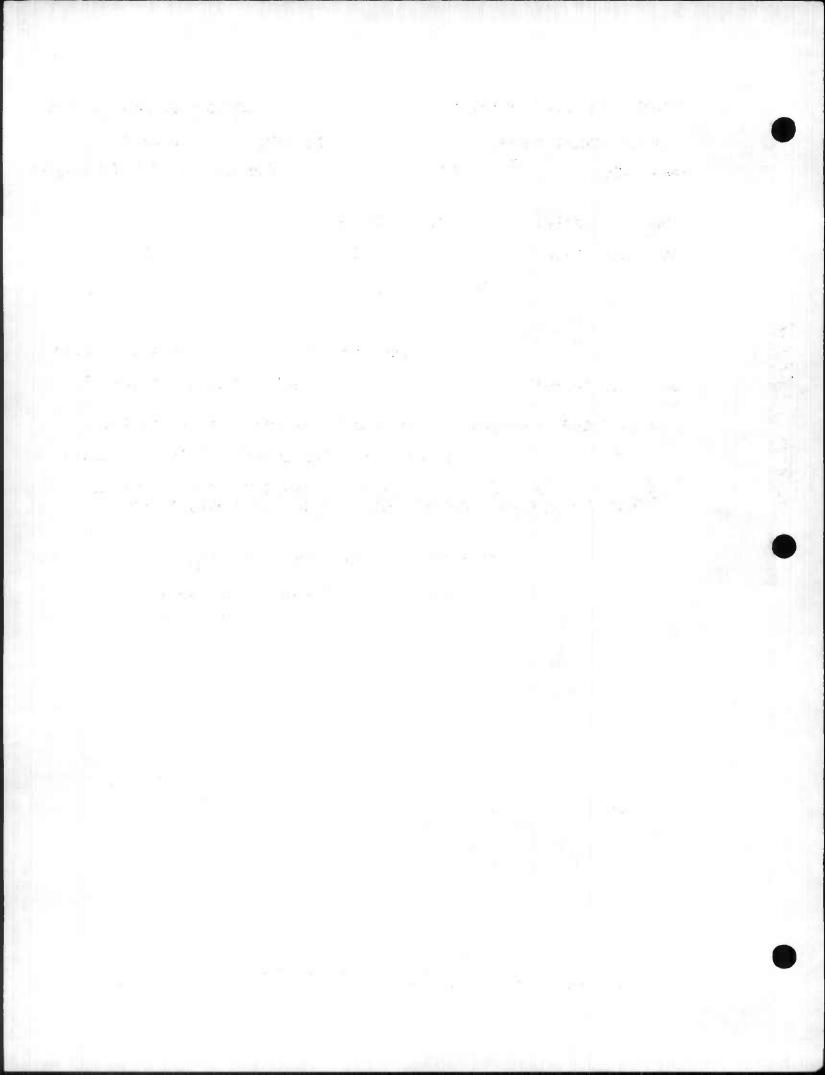
221173

11345 PEMBROOKE SO

29d. Dete signed (Month, Day, Year) 11/22/95

20603

To the Hospital or within 24 hours aft To the Funerel Di completaly filled in



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Dharatai		1. Decedent's Name (First, Middle, Las	()		Ceri	tificate of	Dealli	2. Date of De	Day	Year	3. Time of Death
Physicia /Medic	al	Elva	Blanch		dd			Novembe	er 22, 19	99	8:55 am
Examin	er	4a Facility Neme (If not institution, give					4b. City, Town, or		4c. County		
Funeral		Residence: 450 H 5. Sociel Security Number 6. Se	9x 7. A	ge (In yrs. last	birthday)	If Under 1 Year Months Days		D Date of Rid	h v Year)	9. Birthple	l ace (State or Foreign ry),
Director		221 14 2000	□M 2CXF	75	Yrs.	Days	110010	Month, De Dec. 9	,1923	D	élaware
anyland		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, T	own or Loc		.11			10	d. tnside City Limits
M e M	ect o	Maryland Ceci	LL			_	erryville				
death with the Maryland ms 23a or 28a-f show cmust be notified at	Funeral Director	10e. Street and Number 450 Harford Street	et			10f. Zip Code	21903		10g. Citizen of W U	.S.A.	•
5 28	by	11. Marital Status 1 Never Merried 2 Married 3 XXVidowed 4 Divorced	12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates:	?		/es Decedent of Yes, specify Cut	Hispanic Origin? (5 an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Black Specify:	- America k, White, e	
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglane. Important if them 27 is marked other than "natural", or frams 23s or 23s-f show my injury or other treumatic event, the Medical Evantine must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12) Twelve Years	ucation de completed) College (1-4or		6a. Decede (Give k life. D	ent's Usual Occu ind of work done O NOT use retire Bookkee	during most of wo	vking		Ford	Company Maryland
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arylan should be and Mental marked of umaric eve	To B	Lei	coy W. Wa	ters				Elva J.	David		
Mary		19e. tnforment's Neme/Reletionship (7) Elva B. Newman (Da					and Number or R			State, Zip (2064	
Pages 1 and sent of Health mt. If New 27 ny or other 12		20e. Method of Disposition 12 Burial 2 Cremetion 3 4 Donation 5 Other (Specify		ceme	etery, crem	ition <i>(Name of</i> a <i>tory or other pla</i> Cemetery		Date 11/26/99	20c. Location - O		m, Stete , Marylan
Baltin pemit. Ps Departme Important any injury anns.		21. Signature of Funeral Service poons		(22. Le	Name and Address A. Pa	ess of Facility	Son Fu	neral Ho		, raily rain
		23s. Part1. Ester the disease, or comp shock, or heart failure. List only of	lications thet cause	the death.			e, Maryla				Approximete
Physician /Medical Examiner	er	Immediate Cause (Finel disease or condition resulting in death)	€	Due to (or be	no	eng					Intervel Between Onset and Death
OC/OU, ficete be executed physicien and st the buriel-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	Due to (or as							
- E D 0		resulting in death) Last	d	Due to (or as	a consequ	estob ory.					
the death certy the attending	icia	Pert II. Other significant conditions co	otributing to death I	out not resultin	o in the un	derlying cause of	ven in Part I	23h Did	lobacco usa con	tribute to	the cause of death?
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The lew requires that the hes been signed b page 2 should be dete	Completed by								an eutopsy med?	CONT	re autopsy findings ilable prior to apletion of cause eath?
	S							10	res XX No	10	Yes 2□ No
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John J. Goodill, M.D. 200 Glasgro File. Ste 113 Newwell, DE 19108.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Frances Welsh November 15, 1999 4b. City, Town, or Location of Death 4c. County of Death 0345 a.m. 4e Facility Name (If not Institution, give street end number) Sacred Heart Hospital Cumberland Allegany If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day Year) Aug 20, 1909 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1□M 2□ Months Hours 220-52-7596 90 Yrs. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Tyres 2 □ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. Liberty Street Apt. 610 21502 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 2. 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ Ae 1 Never Married 2 Married 1□ Yes 2□No Specify: Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Sacred Heart Hosp 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis P. Graney Bertha 19e. Informant's Neme/Relationship (Type, Print) Dellann Campbell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Liberty Street; Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, cremetory or other place) 1 Laurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) SS Peter Paul Cemetery11/18 Cumberland, MD 21. Signature of Funeral Sec 22 Scarbellig Funeral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or confplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final (Lenal disease or condition resulting in deeth) Arteriosclerotic Heart Disease unknown Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Na/18 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 reumon to 1 ☐ Yes 2 No 3 Probably 4 Unknown Myocardial Inharction 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Department 2 ER/Outpatient 3 DOA Yes 20 LEAS 00 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner

Department of Health at Important: If Nem 27 is any Injury or other trau

Physician

/Medical

Examiner

Director

Funeral

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Completed

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23a or 28a-f

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. wtt. if item 27 is marked other than "netural", or ite

Hygiene.

aftimore, Maryland 21215-0020

Hospital or Attending Physician: The law requires that the death certificete be executed P.O. Box 68760. the USB as signed by Division of Vital Records. 99 certificate funeral director. this After the

Physician/Medical Examiner þ Be Completed edical Certification: To

s after death. filled in by To the Hospital of within 24 hours a To the Funeral D completely

27. Menner of Death 1 Edivaturel 2 Accident 3 ☐ Suicide

4 | Homicide

29e. Certifier

5 Pending investigetion 6 Could not be

28a. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Curtifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

29b. Signeture and title of countries

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who compl use of deeth (Item 23a) (Type, Print) homa K 620

31. Dete filed (Month, Dey, Year) 1 8 1999 NOV

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Registrar

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NOV 18 1990 James & Sports

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State of Maryland / Department of Health and Mental Hygiene 99 3777L

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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completaly filled in by the funeral Director.	a concar	(Check only 2 Medical one)	Exami	ner: On the	basis of e	examinetion	and/or in	vestigetion	, in my c	ppinion, deeth	occur	ed at the time	, date en	d plece,	end due to	the ceuse(s)	
	omp		29b. Signeture end title of certifie	1	1				29	. Licens	se number			29d. D	alle signe	d (Month,	Day, Year)	
	F 5 F 0		m/m	-	21))				13	368	(11	122	195		
		-	30. Name and eddress of person	who an	mpleted	ued of de-	ath (ltors 22	a) (Tues	Dript\	J ,					-	1 . 1		_
										E1.4-	rahee	o 1	narylan	d	2178	1/1		
	State		Michael McEvoy 31. Date filed (Month, Day, Year)	, M			's Signature	4	way,	FIGE	rspur	5, I	arytan	u	21/0	-		
	State Registra	7	NOV 9 9	100	q	bene	Section 1	19		000	Kal							
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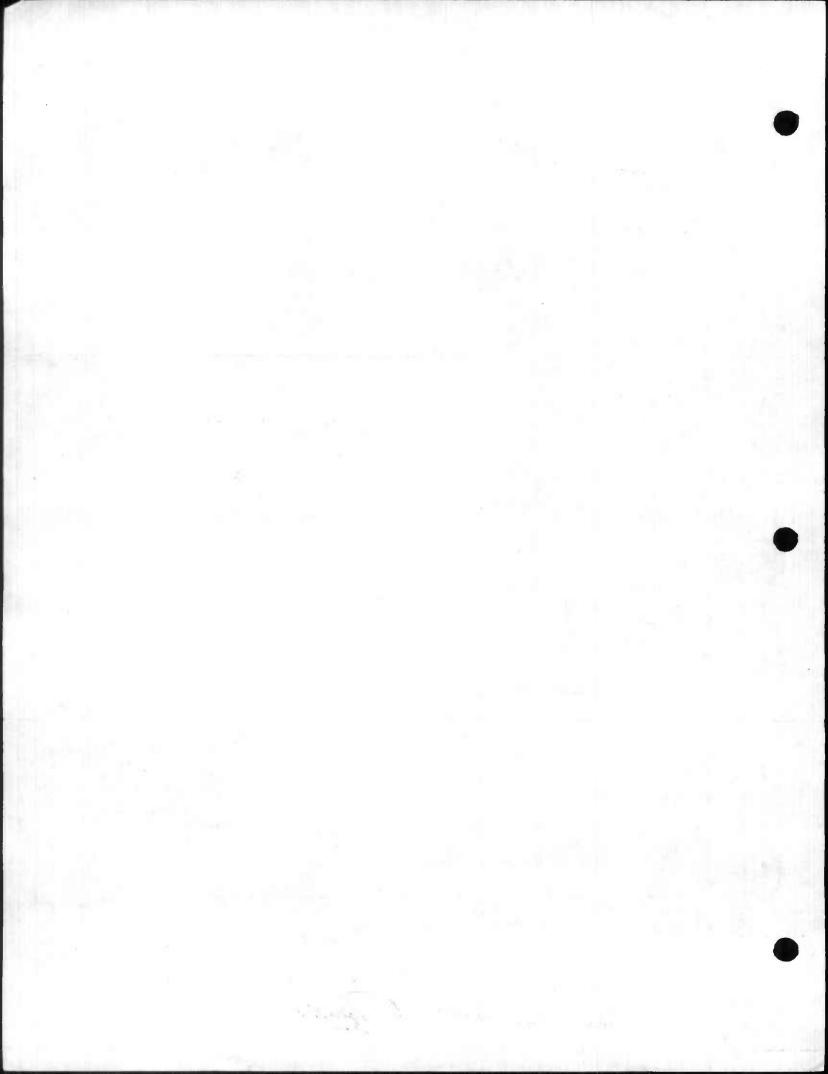
99-6645-0	01. ndul # 8, nds, Please 12/99, Allegany Co,	Type or Print In E	Black Indelibi	le Ink.	Assure All	Coples	Are Legil	ble.	
LAUREN MI	12/99, Hilligany Co. CHELLE WILLIAMS ITEMS: #23 PART	State of Marylan I. 27 28A-	PERME	nt of H	ealth and Modern	99 WR	jiene 9 (37	775
Physician '	1. Decedent's Nama (First, Middla, Last Lauren Michelle)				2. Data of Dea Month NOV •		Year	Tima of Death 9:10 AM
/Medical Examiner	4s Facility Nama (If not institution, giva 13600 WILLIAMS			4	b. City, Town, or Loc CUMBERLAN		4c. County ALLE	of Death	
Funeral Director	217-45-0155	7. Age (In yrs. ☐ M 2DXF	Months	or 1 Yaar Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Pay)Ct. 30	Year) 1000	9. Birthplace Country)	(Stata or Foraign
the Maryland 28e-f show notified at rector	Usual Rasidence of Decedent 10a. Stata 10b. County MD ATTegany		y, Town or Location				2004		nside City Limits
5 68 0	10e. Street and Number 13600 Williams F			ip Code	1502	1	10g. Citizen of V	What Country?	
020 urs after death v et, or items 23s Examinet meat by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas:	,S. 13. Was Dec If Yas, sp 1 ☐ Yes		spanic Origin? (Spen, Maxican, Puarto F	cify Yes or No- Rican, atc.)	14. Race Blace Specify	e-American In k, Whita, atc.	
Maryland 21215-0020 d 2 should be filed within 72 hours after and Merial Hygiene. T is merked other than "natural", or its traumatic event, the Medical Examins To Be Completed by Fu	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		life. DO NOT	ork done o	furing most of working	ng	None	usinass/Industr	Y
aryland 2 should be filed and Merital Hygi marked other marks event, 1 To Be Co	17. Father's Nama (First, Middle, Last) Alan Williams				18. Mother's Nama Erin Sha		Maiden Surnam	a)	
, Mar and 2 she sath and n 27 is me ar traum	19a. Informant's Name/Relationship (T)	-			and Number or Rura				
Saltimore, Nemi: Pages 1 and Neptiment of Health moortant; If less 27 my injury or other trins.	Alan Williams 20a. Mathod of Disposition 1 Burial 2 Deformation 3 4 Donation 5 Other (Specify,	Removal from Stata	Place of Disposition (National Author) or Comptany, crematory or	ama of			20c. Location -		Stata
Balt pamit. Departi Importa any inja	21. Signature of Funeral Service Com	Kan	Eline	Funer		Reiste	Reister: rstown,	MD 211	36
Physician /Medical Examiner	Part. Friter the disease, or comp shock or heart tailure. List only of the control of the contro	na cause on each line.	OKE INHAL	ATIO				Inte Ons	roximata rval Between sat and Death
68760, tificate be associted ophysician and as the burial-transit as the different ophysician and as the different ophysician and as the different ophysician and as the different ophysician ophysica	Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events	c	r as a consequence of						
Box 68 seth certificat certificat for use as the clan/Medl	resulting in death) Last	d							
is, P.O. Box 6876(set that the death certificate be speed by the attending physicia be detached for use as the but by Physician/Medical	Part It. Other significant conditions co	ntributing to death but not res	ulting in the underlying	causa give	en in Part I.		obacco use cor /es 2 No		cause of death?
Il Records, P.O. Box 68760, The law requires that the death certificate be assate has been signed by the attending physician as page 2 should be detached for use as the burial. Completed by Physician/Medical Ex						24a. Was a perfor	an autopsy med?	availab	utopsy findings le prior to tion of cause h?
Vital Recentificate he rector, page						17/2	es 2 No	1 de Ya	s 2 No
Vita inclens certific rector	25. Was casa referred to medical axaminer? VXX as 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 C	Othi	26. Place of Deeth			ar (Specify)	
On O ding Ph h. After th funeral	27. Manner of Death 1 □ Netural 5 □ Pending	28a. Data of Injury (Month, Day Year)	28b. Time of A	28c. Injury Work			ow injury occur		
D 9495	2X Accident invastigation 3 Suicide 6 Could not be 4 Homicide detarmined	11-5-99 28a. Place of Injury - At he building, etc. (Specif RE)	9;:104 pma, farm, street, factor SIDENCE		2	VICTIN 28t. Location (S City or Tow ROAD (treet and Numb	OUSE F or or Rural Roo 3600 W LAND.	
Hospi 4 hou Funer fely fiii	29a. Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examina	wledge, death occurre	d at tha tim	a, data and place, a pinion, deeth occurre	nd due to the d	eusa(s) end me	nner es stated	cause(s)
To the state of th	29b. Signature and tale of certifier	and manner stated.	2	9c. License	number .M.E	4	29d. Date signed NOV .	(Month, Day,	
bus	30. Nema and addrass of person who co		n 23a) (Type, Print) 11 Penn St	reet.	Baltimor	e, Marv	rland 21	201	
State Registrar	31. Data filed (Month, Day, Ygar) NOV 12 19	99 32. Allowirar's Signa	iture	par					

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JOHN I	WESLEY END	WILLIAMS ITEMS: #23 PART		aryland /	Departr O Certifi	gent of h	lealth a				9 ;	37776	
S . 1	nysician Medical	Decedent's Neme (First, Middle, La JOHN WESLEY Facility Name (If not institution, give	WILLIAMS	, SR			Ab Cibi Tox		2. Date of Dee Month NOV . cation of Death	27, 199		3. Time of Death 10:55 AM	
E	xaminer	WASHINGTON COUNT		E.R.			HAGER	STOW	V	WASHI	NGTON		
	neral ector	210-90-0001	M 2□F	34		Under 1 Year onths Days	If Under: Hours	Min.	8. Date of Birth (Month, Day July 25	, Year) , 1965	9. Birthp Coun Hage1	lace (State or Foreign try) CSTOWN, MD	
Ih the Maryland or 28a-f show	fied at tor	Usual Residence of Decedent 10a. State 10b. County MD Washi	ngton		own or Location						11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
h with the	at be notified	10e. Street and Number 20306 Youngstoun	CT		1	or. Zip Code 21742	11			10g. Citizen of V USA	Vhat Coun	try?	
5-0020 72 hours after deal	Examiner must be notified at by Funeral Director	11. Marital Status 11/2/Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent II Armed Forces? 1 Yes 2 II If Yes, Give Year or Dates:			Decedent of I s, specify Cub Yes 21X No		gin? (Spe i, Puerto F	cify Yes or No- lican, etc.)	14. Rac Blac Specify	e - Americ k, White, o	etc.	
21215-0020 d within 72 hours at glens.	r, the Medical Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	+)	(Give kind life. DO N	s Usual Occup of work done VOT use retire	during most	t of workin	9	16b. Kind of Bu			
D STEP	2 2	12 17. Father's Name (First, Middle, Last, Robert E. Willia		R	epairm	an			(First, Middle, rkdoll	Musica Maiden Suman		ans	
C 2 00	- m	19a. Informant's Name/Retationship (Nancy Williams	Type, Print) Mother	2	0306 Y	oungst	oun Cl		gersto	or, City or Town,	State, Zip 2174		
Baltimore, semit. Pages 1 a Department of Hear moortant: If Item	ury or oth	20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specif.				n (Name of ry or other pla Cemete		1		Quincy	PA	17247	
Bailt permit. Depart	any inj	21. Signature of Funeral Service Licer	Sou)804 5	0		Broad			ove Fur esboro	PA 17	me, :	Inc.	
Physi /Med Exam	dical liner	Immediate Cause (Final disease or condition resulting in death)	a. DIA	BETIC		ACIDO		cardiac or	respiratory ar	rest,		Approximate Interval Between Onset end Deeth	
760, te be executed	he burletransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as	a consequenc	ce of):					1		
OX 6876 certificate b		that initiated events resulting in death) Last	d	Oue to (or as	a consequenc	>a of):							
P.O. BOX net the death cent d by the ettendin	eteched for use esti Physician/Med	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the under	lying cause gi	ven in Part t					the cause of death?	
	should be d									an autopsy med?	ev:	ere autopsy findings allable prior to mpletion of cause death?	
= F €	director, page 2 should To Be Completed		7						KEY	′es 2□No	1	Yes 2□ No	
0 5 5	ē	25. Was case referred to medical examiner? XXYes 2 No 27. Manner of Death AN Autural 5 Pending 2 Accident Investigation	Hospital: 1 Inpatie	y 28b	Outpatient 3 Time of Injury	28c. tnju Wo	her: 4 🗆 Nu	rsing Hon		ne) lence 6 □Oth row injury occur		r)	
DIVISION To the Hospital or Attending is within 24 hours effer death. To the Funeral Director: After	completely filled in by the funeral Medical Certification: 1	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju- building, etc		farm, street,	factory, office		2	8f. Location (S City or Tow	Street and Numb m, State)	er or Rura	al Route Number,	
Hoepl n 24 hou	pletely fill edical	29a. Certifier (Check only one) 1 Certifying Ph	d place, a th occurre	nd due to the o d at the time, o	cause(s) and made and place,	anner as st end due to	ated. the cause(s)						
To the the the the the the the the the the	M	29b. Signature and title of certifier O.C.M.E								29d Date signed (Month, Day, Year) NOV. 28, 1999			
			mle	111			, Bal	timo	re, Mar	yland 2	1201		
Re	State egistrar	31. Date filed (Month, Day, Year)		r's Signature	B.	Spa	Kel						

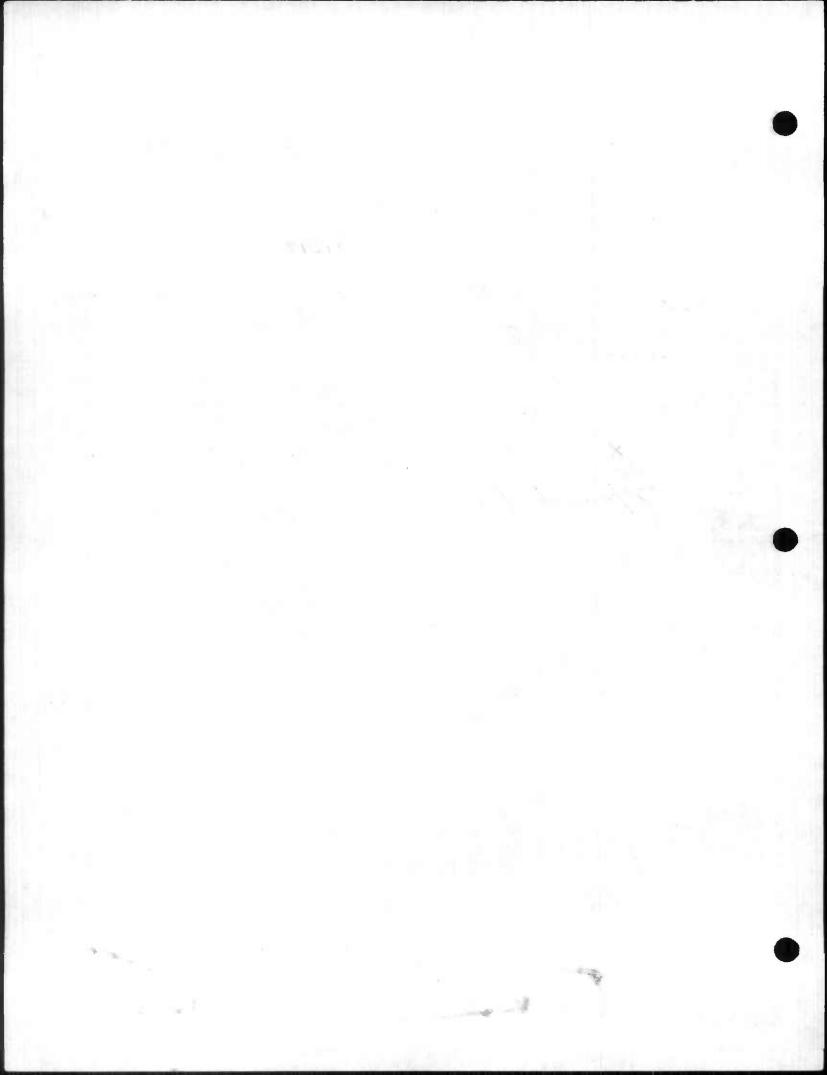


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** JAMES ELWOOD WALTERS 13 Nov. 1999 0630 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner The Memorial Hospital Talbot Easton If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Hours Months Days 213-12-5793 85 oct.17,1914 CENTREVILLE, ME Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits ahow must be notified at 1 Yes 2 No MD. QUEEN ANNE CENTREVILLE Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or harms 23s or 114 FRONT STREET 21617 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 white Specify: þ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 3rd. GRADE LUMBER YARD TRUCK DRIVER LUMBER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be and Mental Important: If Item 27 is marked any injury or other traumatic av LINWOOD C.WATERS LULU BELLE ANTHONY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) (SON) JAMES ELWOOD WALTERS JR. 4939 BAYLOR DR. BARTLESVILLE, OK. 74006 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAK CREMATION NOV. 14 1 ☐ Burial 2 Cremetion 3 ☐ Removal from State STEVENSVILLE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) CENTER LLC.
22. Name and Address of Fecility 21. Signeture of Funeral Service Licensee FELLOWS, HELFENBEIN&NEWNAM FUNERAL HOME CENTREVILLE MD. 21617 our 23a. Pert1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner Orexia burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician s the burial eumonia Box 68760 Physician/Medical Due to (or es a consequence of): signed by the all d be detached for P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Winknown Division of Vital Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Wes an autopsy parformed? Completed 2 No certificate 1 ☐ Yes 1 TYes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Dinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNo Medical Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Diveturel 5 Pending 1 Tes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Cy Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Cartifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner steted. 29b. Signeture and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 19992. Registrate Signature State

Registrar

JAMES WALTERS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Ruth C. Wilson 330 1999 November 16 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Death Union Hospital Elkton Cecil If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 X F Yrs. 222-07-0045 87 Director Nov. 8, 1912 Delaware Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours efter death with the Maryler nent of Health end Mentel Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 23s-f show ury or other traumatic event, its Medical Examiner must be notlined. 1 ☐ Yes 2 No Funeral Director Maryland Cecil Chesapeake City 10e. Street end Number 10g. Citizen of Whet Country? 3058 Old Telegraph Rd. 21915 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: 11. Maritel Status 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: à Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) File Clerk Trucking Industry Maryland 17. Fether's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Meiden Surneme) Harry Thomas Ware, Sr. Elizabeth Unfried 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Frances L. DeCampli 2923 Old Telegraph Rd. Chesapeake City, MD 21915 altimore. 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removel from State Department of important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) A. Ferris & Co., Inc. 11-18-99 West Chester, PA 21. Signature of Funerel Service Licenses R. T. Foard Funeral Home, P. A. 318 George Street Chesapeake City, MD 21915 ichasa ceptions/thet ceused the death. Do not enter the mode of dying, such as cerdlec or respiratory errest, a ceuse on each line. 23a. Pert1. Enter the disease, of complice shock or heart failure. List only on Approximate Intervel Between Onset end Deeth **Physician** Immedian Cause (Finel disease or condition resulting in death) /Medical candle my oputhy 13 chemic years Examiner Due to (or es a consequence of): Physician/Medical Examiner melli Yes The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Anterio sclerosis the Due to (or es e consequence of) for use es Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown recurreny Records, 24b. Were eutopsy findings evalleble prior to completion of ceuse of deeth? Completed 24e. Wes en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No of Vital or Attending Physician: Be 25. Wes cese referred to medical examiner? 28. Place of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ER/Outpetient 3 ☐ DOA To the Hospital or Attending rupous within 24 hours effer death.

To the Funeral Director: Affer this o Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 8 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed ceuse of deeth (Hem 23e) (Type, Print)

W. Bruce Obenshafn, 25/5. Cohemia Ave., Cecilton, md. 219/3 32. Registrer's Signature State books NOV 1 9 1999 Registrar

DANNY WALLS Baltimore, Maryland 21215-0020

9				State of Mar		Department Certificate				giene ,	. 0	7770	
			1. Decedent's Name (First, Middle, La	st)					2. Dete of De	eth	J	3. Time of Death	
п	Physicia /Medic		Danny Edwin	Walls					NOV NOV	20 Dey	1999	4:51 A:M	
ñ	Examin		4e Fecility Neme (If not institution, giv					4b. City, Town, or I	Location of Deat	,			
	باللبيا		CIVISTA MEDICA					LAPLAT			HARLE	S	
	Funeral Director		5. Sociel Security Number 6. S 235-56-2351 Usual Residence of Decedent	X M 2 F	(In yrs. lest birt	thdey) If Under Yrs. Months	1 Year Deys		(Month, Da	1, 1938	9. Birthpi Count West	lece (State or Foreign try) Virgini	
	year a		10e. Stete 10b. County	1	Ioc. City, Towr	or Location					10	0d. Inside City Limits	
	Men H	ţ	MD Charl	es	La I	Plata						1 Yes 2 No	
	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of	Whet Coun	try?	
	23a	Funeral D	104 East Haw	thorne Dr	ive		20)646		U.S.	Α.		
20	020 urs e		11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Detes:		13. Wes Deced If Yes, spec		Hispanic Origin? (S an, Mexican, Puert Specify:	pacify Yes or No o Rican, etc.)	Specify	Rece - American Indien, Bleck, White, etc.		
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<u>\$</u>	should be and Mental marked o	ဠ	Donald Eugene					Ada Vic					
Mai			19a. Informant's Name/Relationship (and Number or Ru				Code)	
-	1 and Health em 27		Anne Suzette Mar 20a. Method of Disposition	uda/compa	20b. Place of	Disposition (Nam	ne of		Plata,	MD 20		wn. Stale	
Baltimore	Pege nnt: H i		1 Buriel 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specif	v)	Bridg		Cen	netery 1	1/24/9				
Bal	permit. Pe Departmen Important: any injury bace.		21. Signalure of Funeral Servica Licer	Elio	the .	P.O.	art	E-Echols	a Plat	a, MD	e, P 2064	.A.	
	Physician /Medical Examiner	ler	23e. Part1. Enter the seese, or comshock, or heart ailure. List only Immediate Cause (Final disease or condition resulting in death)	a. rugstur								Approximete Interval Between Onset end Death	
lox 68760,	leath certificate be executed the effect of the second of	Physician/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in death) Last	D.	ue to (or es e d	consequence of):	(
B.	death en enten ed for u	sici	Pert II. Other significant conditions of	ontributing to death but	not resulting in	the underlying ca	ause gi	ven in Pert I.	23b. Dld	tobacco uee co	ntribute to	the cause of death?	
s, P.O	es that the de igned by the be detached	by Phy							1 🗆	Yes 2□ No	3 Prot	pably 4 Unknown	
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Division	ding h. After fune	27. Menner of Deeth 1 Neturel								28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number,			
Ö	무를	Cert	4 Homicide	building, etc.	(Specify)				City or To	wn, Stete)			
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		ŀ	20 Name and address of subsecutes	completed source of dea	th (Hom OZa) (Time Driet)				-			

575 MAIN STREET SUITE 253 LAUREL, MD 20707

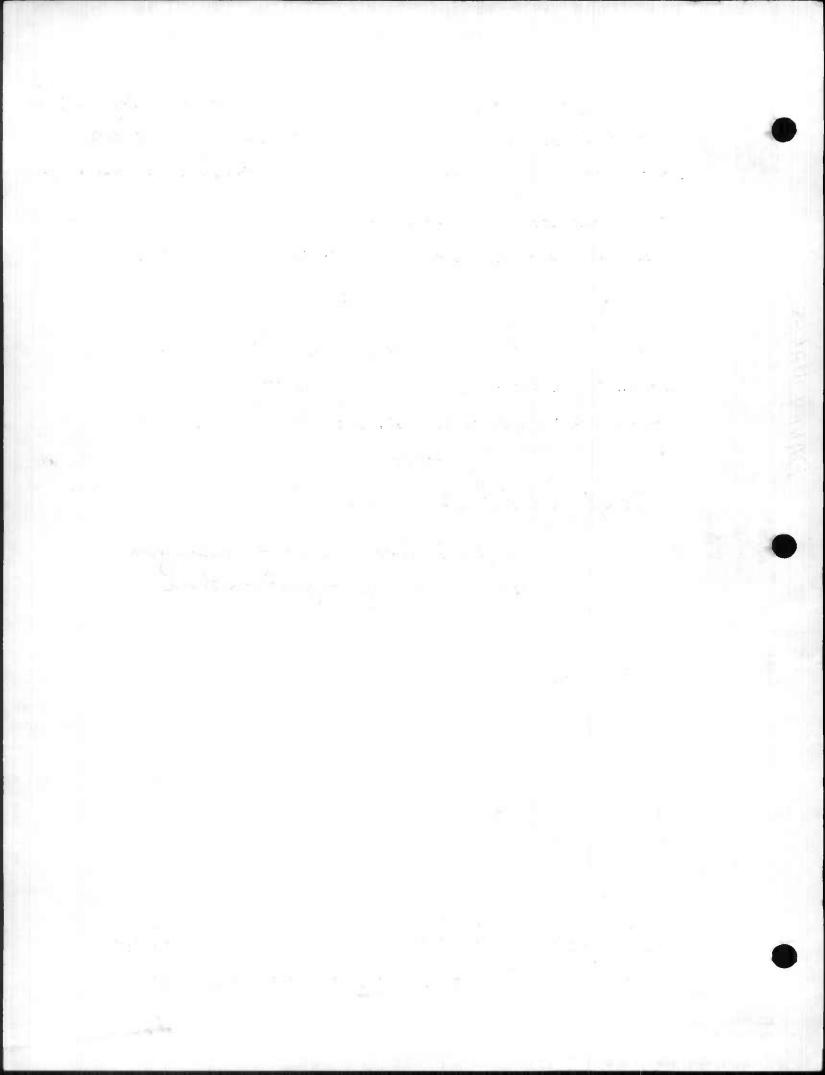
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

State Registrar RANDOLPH A. DECARLO MD

32. Registrar's Signeture

31. Date filed (Month, Dey, Year) NOV 2 2 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

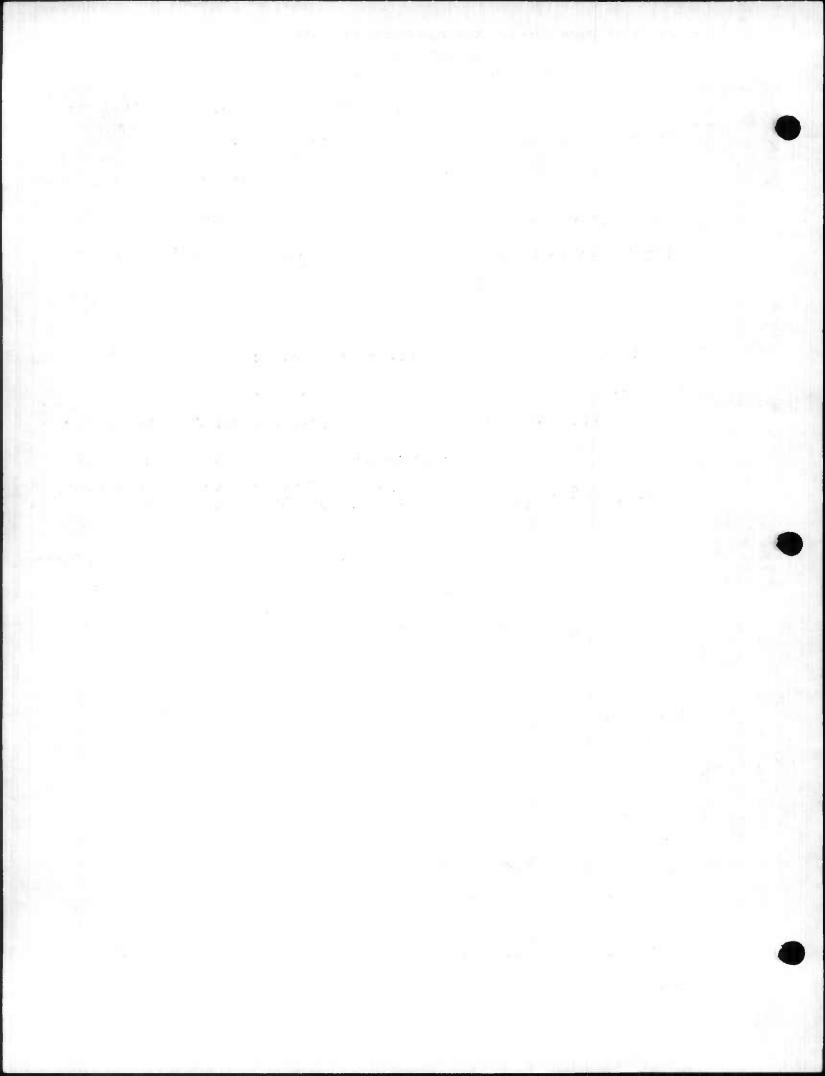
State of Maryland / Department of Health and Mental Hygiene

37780

					Ce	ertificate o	f Death		Reg. No.		01100
	Physic /Medi		Decedent's Nama (First, Middia, Las	Floyd Mo	rel Ze	igenfus		2. Data of D Month NOV.		9 ^{Year}	3. Tima of Death 12:03 PM
7	Exami		4e. Facility Nama (If not institution, give 502 Routzahan				4b. City, Town, or Federal	sburg		of Death Oline	e
	Funeral Director		5. Social Security Number 6. Si 179-12-6356 1 Usual Rasidance of Decedant	7. Aga (In	yrs. last birthday 87 Yrs.	Months Day		8. Data of B	irth ay, Year) 26,1912	9. Birthpla Countr	ace (Stata or Foreign ry)
	death with the Maryland ms 23a or 28a-f show	ctor	MD Caroli		c. City, Town or I	Location	Fede	ralsb	ırg	10	d. Inside City Limits
	ath with the 23a or 2	Funeral Director	10e. Street and Number 502 Routzahan	Lane		10f. Zip Coda	21632		United		*
5-0020	or ite	by	11. Maritel Status 1 Navar Marrled 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar Armed Forces? 1 ☐ Yes 2 ☑ No if Yas, Giva Yaar or Datas:	in U,S. 13	. Was Decedant or If Yes, specify Cu 1 ☐ Yes 2 ☒ N	f Hispanic Orlgin? (Suben, Maxican, Puar o Specify:	pecify Yas or N to Rican, atc.)		e - Amarica ok, Whita, a r: Whi	tc.
2121	ne.	Be Completed	15. Decedant's Ed (Specify only highast grad Elemantary/Secondary (0-12) 10th	ucetion da com <i>piatad)</i> Collaga (1-4or 5+)	(Giv iifa.		Mechani	С	Agric	ultu	
Maryland	should be filed vand Mental Hygie merked other tumatic event, to	To Be	John Zeigenfus				Nora	T. Bar			
	and 2 sh ealth and na 27 is m		19a. Informant's Name/Ratationship (7 Wayne Williams	on/Friend	165	7 Tall	at and Number or Re Tree Dr	.East,	Jacksor	nvill	e,FL
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Manit Important: if Item 27 is marked any injury or other traumatic e once.		20a. Mathod of Disposition 1 ☒ Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify	Ramoval from Stata	camatary, cr	position (Nama of ematory or other p Cemeter		11-26	Boyert		
Ball	permit. Depart Import any inj		21. Signatura of Funeral Sarvica Licen	see see	F	ramptor	drass of Facility M-Hawkin Main St.	s-Esko	w Fune	ral I	lome, PA 1D 21632
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ox 68760,	certificata be executed nding physician and use as the burial-transit	//Medical	Sequantiatly list conditions, if any, laading to immadiata ceusa. Entar Undartying Causa (Disaasa or Injury that initiated avants rasulting in daath) Lest	c. ~~~		olve	res	~~5	1-1-		3 462
s, P.O. B	res that the death igned by the atter be detached for u	by Physician	Part II. Other significent conditions co	ntributing to death but no	t rasulting in tha	undarlying causa	givan in Part I.		tobacco use co		the cause of death?
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DHMH 16 Rev 6/95

Registrar



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or 28a-f s be notified	10e. Street and I					10f. Zip C	ode			10g. Citizen o	of Whet Cor	untry?
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110 V 2 3 1999 Journe 15 Aproxim

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month **Physician** December /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 24 Hrs. 8. Hospital Inai If Under 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days 25-36-315 1 M 2 F Director Usual Residence of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow notified at 1 Yas 2 No licott Funeral Director Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or U.S 21042 14. Race - American Indian, Black, Whita, atc. Hems ; 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status r than "natural", or iten the Medical Examiner Pagas 1 and 2 should be filed within 72 hours after ment of Healin and Mental Hygiene.

mt: If item 27 is marked other than "natural; or the ury or other treumatic event, my and reference in the manual matural and the feature in the manual matural Never Married 2 Married 1 ☐ Yas 2 ☐ If Yas, Giva Yaar or Dates: 2 No Black 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Westinghouse Elemantary/Secondary (0-12) College (1-4or 5+) 11th grade NA perator Baltimore, Maryland 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Anderson dward Grines 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 21042 1888 11cott City Ma aughter 20b. Place of Disposition (Nama of partial place) 20a. Method of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Removal from State Department of important: If eny injury or 4 ☐ Donation 5 ☐ Othar (Specify) emetery 32, Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licensee .H. anc waltest Md 2/2/5 Avenue dications that caused the death. Approximata Interval Between Onset and Death 23a Part 1. Entar tha disaasa, or com Do not enter the mode of dying, such as cardiac or respiretory arrest, **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) **Examiner** Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disaase or Injury that initiated events rasulting In daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): signed by the attending be detached for usa 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yas or Attending Physician: 25. Was casa rafarred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medicai Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar Division 1 Swatural 5 Pending 1 ☐ Yas 2 ☐ No within 24 hours aftar death. To the Funeral Director: A 2 Accident invastigation 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 ☐ Homicide the Hospital 29a. Cartifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

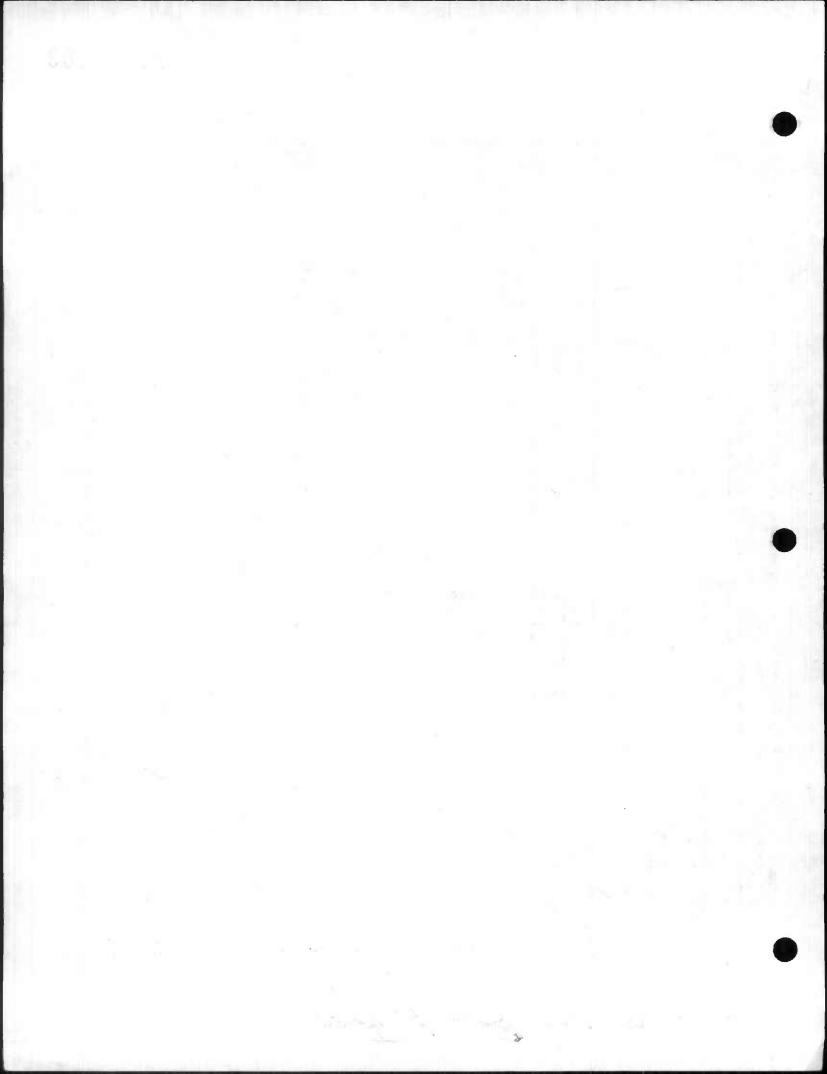
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	Decedent's Name (First, Middle, Las	State of Mary	Certi	ficate of	Death	2. Date of D	Reg. No.	37	783
Physician		A 11				Month Month	Day	Year	3. Time of Death 2003
/Medical	Jernice 4a Facility Name (If not institution, give	HIPO		14	lb. City, Town, or	Location of Dea	th 4c. County	99	2005
Examiner	University of Mar		c. 1 Center		Baltin			IA	
Funeral	5. Social Security Number 6. Se		yrs. last birthday)	f Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth .	9. Birthplac	e (State or Foreig
Director	214-30-5464 1	□M 21xF 66	Yrs.	Months Days	Hours Min	07-1		Country	SC
ehow ed at	10a. State 10b. County MD NA		c. City, Town or Local					10d	. Inside City Limit
vith the Meryle t or 28a-f sho be notified at Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	After Country	
\$ 9 B	1502 W. Fayet	te Street	Apt. "A		.223		USA		
ar, or he remine by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 July Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates:		s Decedent of H es, specify Cubs	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or Note 1 N	Specify	e-American ck, White, etc	
"netural", ofer E.	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deceden	t's Usual Occup	ation during most of wo	dring	16b. Kind of Bo	siness/Indus	stry
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d other went, Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Suman	16)	
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2 should and Men is marke sumatic	19a. Informent's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street	and Number or R	ural Route Numb	ber, City or Town,	State, Zip Co	ode)
of Health of Health if Item 27 i	Cheryl Da	venport	849 E	Bradhur	st Roa	d Balt:	imore,	MD. 2	21212
0 = 0	20a. Method of Disposition **Description A Donation B Donation	Removel from State	20b. Plece of Dispositi cemetery, cremate Loudon F	on (Name of lony or other place) ark Ce	metery	12-06	20c. Location - 99 Bal	timor	
Demit. Pe Departmen Important: any injury anga	21. Signalure of Funeral Service Licens		22. N	eme and Addres	ss of Facility B	altimo	re, Mar	vland	21202
Depart Person	1 Ten Cl	her tax					. North	-	
net the deeth certificate be associted by the attending physician and letached for use as the buriel-transit. Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due c.	neum en l'ac o to (or as a conseque						
he attented for un	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the unde	orlying cause giv	en in Pert I.	23b. Did	tobecco use co	ntribute to th	ne cause of deal
Ph etac						1	Yes 2□ No	3 Probal	bly 4 Denkno
2 should						24a. Wer	s an autopsy ormed?	availe	autopsy finding able prior to eletion of cause ath?
Page Corr						10	Yes 28 No	101	res 2 No
s certificata ha director, page To Be Com	25. Was case referred to medical examiner?	Hospital:	-/-	Oth	or	ath (Check only			
this certific ral director, TO Be	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3D DOV	4Li Nursing I	T	idence 6 Oth		
r death. sctor: After by the funer lification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	er) 280. Time or Injury	28c. Injury Work	yat k? Yes 2 ☐ No	200. Describe	now allury occur	190	
18 5 E	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, ferm, street pecify)	, fectory, office	ce 28f. Location ((Street and Number or Rural Route Number, rown, State)		
within 24 hours a within 24 hours a Completely filled	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Example	raician: To the best of miner: On the besis of exa	mination and/or inves	courred at the tin tigation, in my o	ne, date and place pinion, deeth occ	e, and due to the urred at the time	cause(s) and ma , date and place,	anner as state and due to th	ed. ne cause(s)
o the	29b. Signature anytititle of certifier	A		29c. Licens	e number		29d. Date signe	d (Month, Da	y, Year)
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1	30. Name and address of person who c	11 1 -1	(Item 23a) (Type, Pri	nt)		0 1		100	
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	lond Bi	redical	Certer			
State Registrar	DEC 3 1999	A .	4	loca V	,				
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** DECEMBER 1, 1999 Pauline Elizabeth Arputham 4:25 AM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Examiner Saint Joseph Medical Center Towson If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex If Under 1 Year Months Deys 7. Age (In vrs. last birthdev) Birthpiece (State or Foreign Country) **Funeral** 1 M 2 F Director 213-51-1354 45 Sri-Lanka Usuei Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Rosedale 1 ☐ Yes 2 No Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9 A Maidstone Ct. 21237 pemit. Pagas 1 and 2 should be filed within 72 hours attar death a Department of Haalth and Menial Hygiena. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Example Traustones. United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 11. Maritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Deles; 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Years Teacher Day Care 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be 2 Oscar M. Schokman Edna M. Schokman 19a. Informant's Neme/Relationship (Type, Print) (Husband) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9 A Maidstone Ct. Mr. Soosaimarian Arputham Rosedale, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete ₩3Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holy Rosary Cemetery 12/3/1999 Baltimore, Maryland 21. Signeture of Fureral Service Licensee 22. Neme end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 21222 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete intervei Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) METASTATIC CARCINOMA OF THE PANCREAS MONTHS /Medical **Examiner** Due to (or es e consequence of): The law requires that the death certificate be executed physician end tha burial-transit Exam Sequentielly list conditions, if eny, laading to immediata cause. Enier Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Dua to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): 60 usa signed by the et d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 2 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 has 2 2 No certificate 1 Yes 1 ☐ Yes 2 No Hospital or Attending Physician: funaral director. Be 25. Wes case raferred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Aftar this 28a. Dete of Injury (Month, Dey Year) 27. Mennar of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Natural 5 ☐ Pending 24 hours after death. 2 Accident investigetion 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 Sulcide 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) filled in by 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the causa(s) and manner as stated.

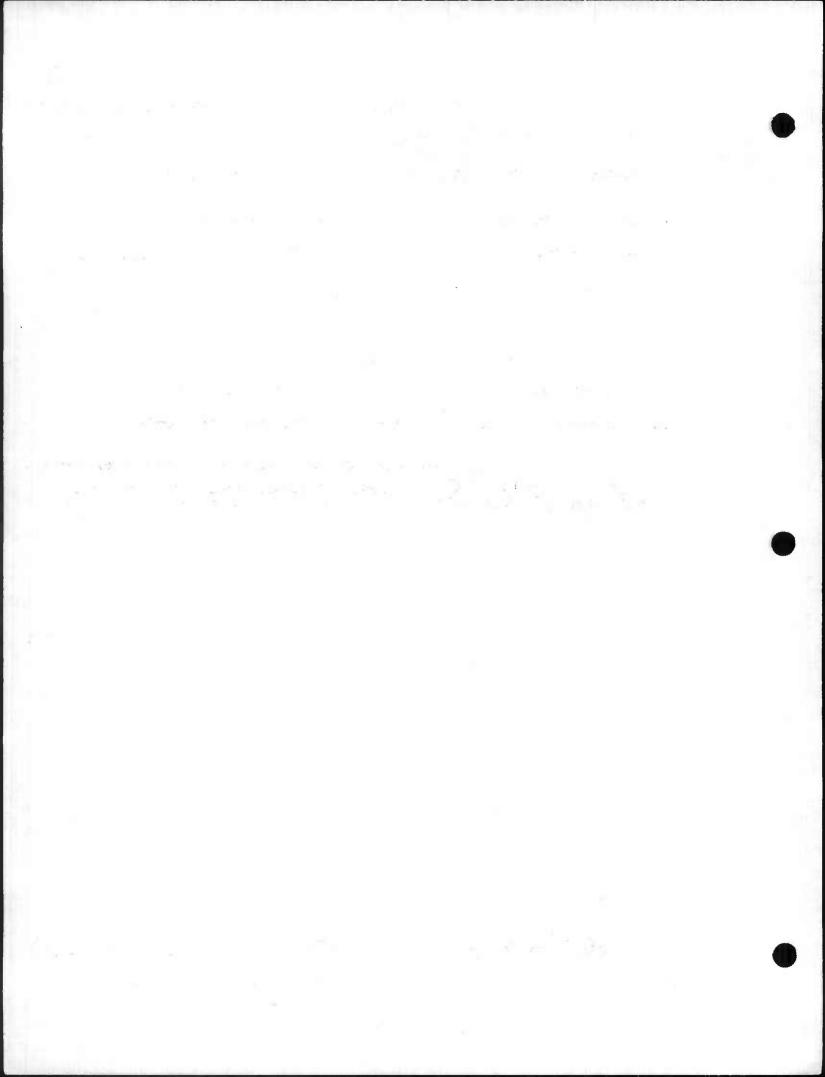
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, data and piece, and due to the causa(s) and manner stated. edical To the Hosp within 24 hou To the Fune complately fil 29e. Cartifian 29b. Signeture end title of pertifier 29c. License number 29d. Dete signed (Month, Dey, Year) D25886 0 30. Neme and address of parson who completed cause of deeth (item 23e) (Type, Print) LILIA CEBALLOS M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

Registrer's Signeture

Art

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) DEC.2,1999 4:25 A.M HESTER CATHERINE SMITH BUTTS 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 4132 SUNNYSIDE AVENUE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Months 1□ M 2₩ F 220 22 3063 Yrs. DEC.6,1921 MARYLAND Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 Yes 2 No MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21215 U.S. OF A. 14. Race - American Indien, 4132 SUNNYSIDE AVENUE 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 □ Divorced BLACK 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN UNKNOWN FAMILY CARE PROVIDER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DORA THOMAS SMITH ELLSWORTH SMITH 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTO., MD. 21215 20c. Location - City or Town, State CHRISTOPHER TITTLE, SR. (SON) 4132 SUNNYSIDE AVENUE Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 1 Burial 2 Cremation 3 Removal from State PK. 12/7/99 4 ☐ Donetion 5 ☐ Other (Specify) LAUREL, MD. A.A. Co. NAT. MEM. MD. 21. Signature of Funeral Service Ligensee LEWIS T. GWYNN LEWIS T. GWYNN LEWIS T. GWYNN FUNERAL 4517 PARK HEIGHTS AVENU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LEWIS T. GWYNN FUNERAL HOME 21215-6393 PARK HEIGHTS AVENUE Approximate Intervel Between Onset and Death a Atheroselesote Cardio vosulos disease Immediate Cause (Final disease or condition resulting in death) Hypertension Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequenca of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 TYes 2 No. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident

physicien end the bunal-transit Box 68760, certificate be 58 USB ō P.O. Records, 50 peen page 2 certificete Division of Vital Attending Physician:

6 Hospital

Physician

Examiner

/Medicai

Examiner funeral director. Certification: To

After this 24 hours efter deeth. filled in by

Physician

· /Medical

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permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryle Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 23a-f show any injury or other treumatic event, ire Medical Examiner must be notified a once.

Baltimore,

Physician/Medical à Completed

Medical To the Hosp within 24 hor To the Fune completely fi State

(Check only one) 29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 ☐ Homicide

6 Could not be determined

I Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner as steted. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated.

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29c. License number D 175 37

29d. Date signed (Month, Day, Year)

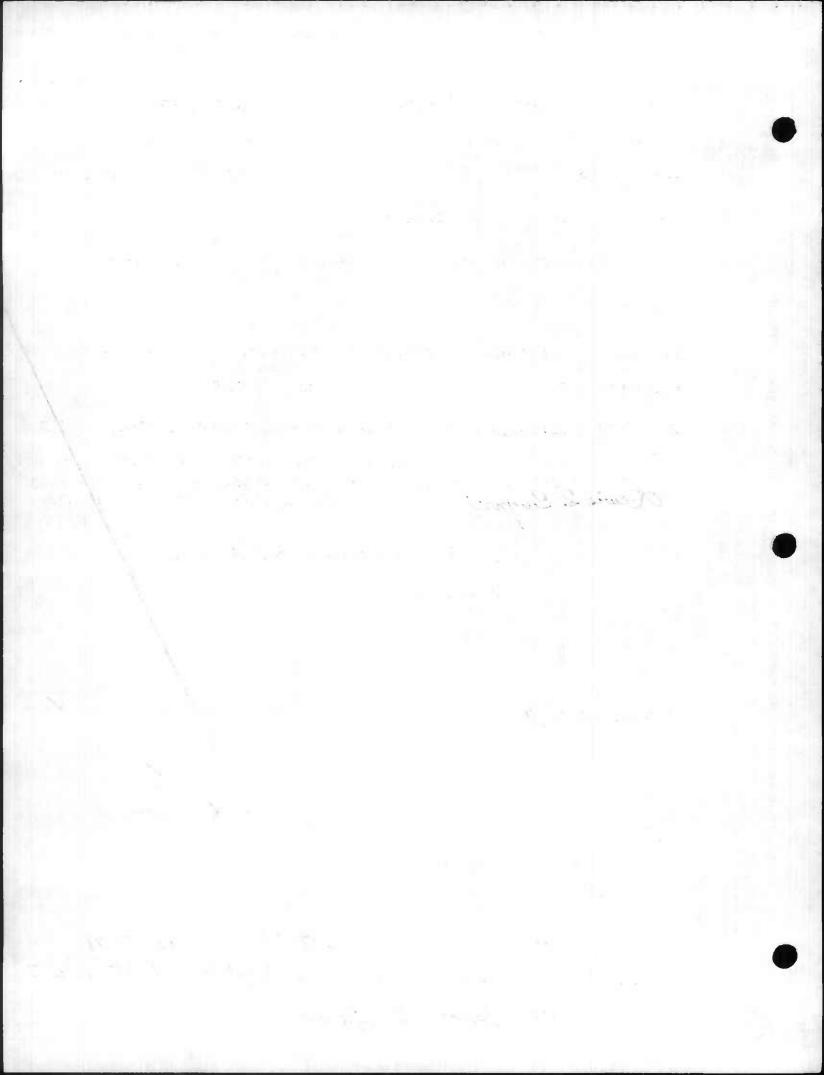
Location (Street and Number or Rural Route Number, City or Town, State)

(600 W. MOUNT Royal Ave, Balto use of death (Item 23a) (Type, Print) -UJAMD

31. Date filed (Month, Day, Year) DEC 03 1999

32. Registrar's Signature

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

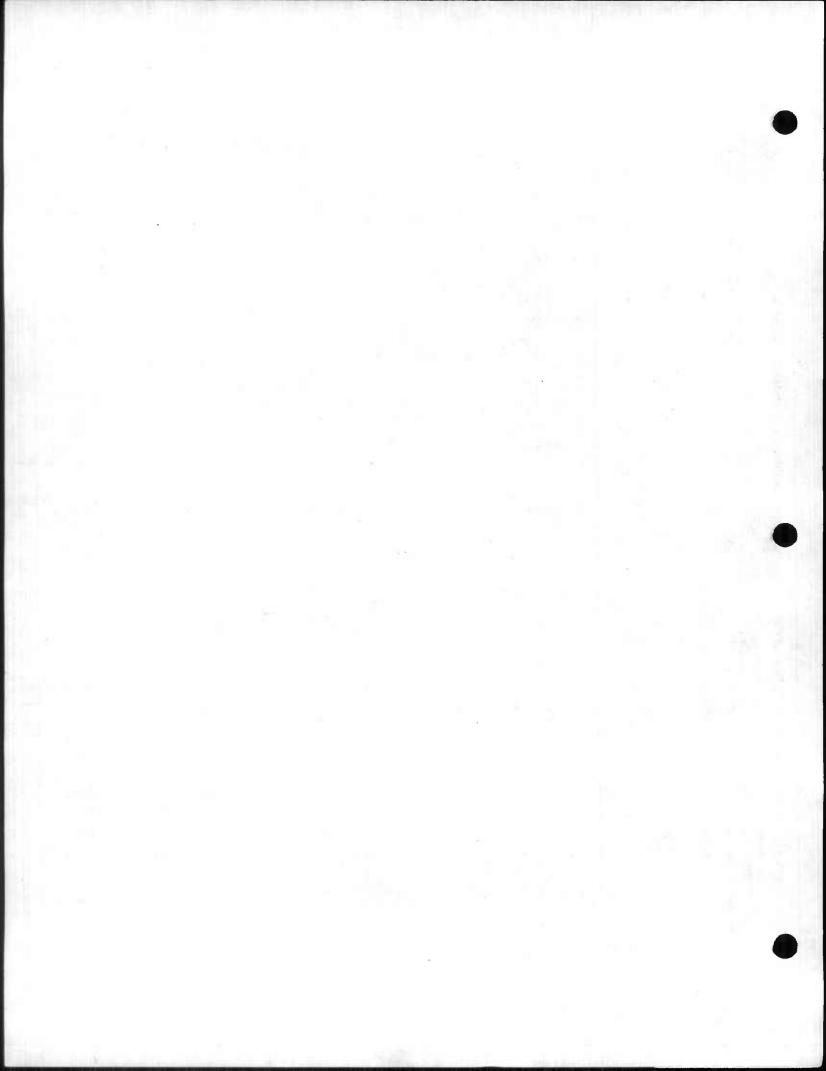
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Year **Physician** Martha Branch 23:42 November 25 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F 2-34-7903 Vrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f ahow Examiner must be notified at 1 Yes 2 No Director Himore 10a, Street and Number 10f. Zip Code 10a. Citizen of What Country? U.S.A 21205 mo 5%. 2626 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Meritel Stetus Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: Never Married 2 Married natural, or Baltimore. Maryland 21215-0020 1 Yes 2 No A BIACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Cook 16 th KOTURANT /A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental important: If item 27 is marked or any injury or other traumatic avance. BRANCH Solia Gillian 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Kentucky Baltimore, Md. 21205 LUE. reak 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 10/0/99 Baltimore oshel 4 Donetion 5 Other (Specify) Ceneter. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Betts tuneral 1129 N. CAroline St. Baltimore, d. 21213 23a Part Enter the disease, of complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final obstructive week Meumonia disease or condition resulting in death) Examiner Physician/Medical Examiner sauamous year cell be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown tailur renal Records, Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? braun completion of cause of death? 1 Yes 20 No Division of Vital Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certifica stell filled in by the funeral director; p 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) TNo Medical Certification: To 1 Yes 27 Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 24 hours The Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe HOOKIN Balhmor, Street 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parks 1999 DEC 03 Registrar

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DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

		State of Maryland / Department of Health and M AMEND#7&8 PER F.H. G778 12-21-99 J.A. Certificate of Death		giene Nog. No. 99	37787
	Dhusisian	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ith	3. Time of Death
1	Physician /Medical		Decembe		
	Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		4c. County of E	Death
	4	764-E Fairview Avenue Annapoli 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) M. Under 1 Year M. Under 24 Hrs.			Arundel
ı	Funeral Director	226-34-2834 11XM 2DF 75 74 Yrs. Months Days Hours Min.		, Year)	Birthplace (State or Foreign Country) /irginia
	pue *	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	(aho	MD Anne Arundel Annapolis			1 ☐ Yes 2 ☑ No
	or 28s-falls or 28s-falls	MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	t Country?
	3a o	764-E Fairview Avenue 21403		USA	
	r Herne 234	11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	city Yes or No-		American Indian,
020	within 72 hours after death with the Manyland ene. than "natural; or items 23s or 28s-f show he Medical Examinat must be notified at empleted by Funeral Director	Amed Forces? 1 Never Married 2 Married Types 2 No Types 3 No 3 Widowed 4 Divorced Types 2 No 1 Yes, specify Cuban, Mexican, Puerto I 1 Yes, specify Cuban, Mexican, Puerto I 1 Yes 3 No Specify:	racan, etc.)		White, etc. White
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21215-0020	od within 72 ho ygiene. her than "naturn ft, fre Medical Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working it.e. DO NOT use retired)	10		
999	Digital O	4 Musician 17. Father's Name (First, Middle, Last) 18. Mother's Name	Clima Mindella	Music	
Maryland	s 1 and 2 should be filled if Health and Mental hyg item 27 is marked other other traumatic event, I	17. Father's Name (First, Middle, Last) Newman H. Byrd Mary Lee			
7	thould Me Me Me Me Me Me Me Me Me Me Me Me Me	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			te. Zin Codel
	d 2 ser	Rebecca G. Byrd (Wife) 764-E Fairview Avenue,			
re,	f Heali fram 2 other	20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place)		20c. Location - City	
E	Pages nent of int: If its iny or o	1 District 2 Decremental 3 Differential 3 Different	.2/03	Baltimon	re. MD
Baltimore,	pemit. Pages 1 an Department of Heal Important: If item 2' any Injury or other pace.	21. Signature of Euneral Service Licensee 22. Name and Address of Facility			
0	88558	Hardesty Funeral 1 12 Ridgely Avenue	•		21.401
Г		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory an	rest,	Approximate Interval Between
	Physician				Onset end Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a Carcinoma of the lu-	14		5 y
١.		Due to (or as a consequence of):	J		
1	executed in and ial-transit Examiner	b			
ć	death certificate be executed attending physician and ad for use as the bunk-transit sician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			
8760,	ohysicia the bur dical	that initiated events			
9	5 g s	resulting in death) Last			
Box	at the death certific d by the attending p etached for use as:	d			
0	the dea	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco use contril	bute to the cause of death?
0	£ 60 ~		K	fes 2□ No 3[Probably 4 Unknown
Records,	been sign should be		24a. Was a perfor		4b. Were autopsy tindings available prior to completion of cause
Rec	has has mp		10Y	es 2000	of death?
Vitai	s certificate director, pag	25. Was case referred to medical examiner?	(Check only or	ne)	
of V	Z op Z	Hospital:	me 5 Resid	ence 6 DOther (Specify)
	h. After th funera	1 Natural 5 Pending (Month, Dey Year) Injury Work?	28d. Describe h	ow injury occurred	
Sio	Attanding r death. ctor: Afte by the fune	2 Accident investigation M 1 Yes 2 No	201 Location (C	Manad and Mismbar	or Rural Route Number,
Division	tel or Attending Presents after death. In Director: After ted in by the funeraction by the funeraction:	determined determined determined determined determined determined determined determined determined determined determined	City or Tow	n, State)	r nural noute Number,
		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the c	ause(s) and manne	er as stated.
	the Hospi hin 24 hou the Funer npletely fil	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, d	date and place, and	due to the cause(s)
	To the within To the comp	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (A	
		Late t Velum mp 024804		12-2-9	
	30	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rubort T Peterson up 600 Rulely A.	e to	monte	Md21401
	State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rubert T Peterson mb 600 Rulely A. 31. Date filed (Month, Day, Year) DEC 03 1999 32. Registrar's Signature G. Loads	111	1	
	•	- Portar			

JEG 23 1964 January E. Spirite

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Alma Elizabeth Burgoyne 11:55 AM NOV 29, 1999 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Gilchrist Center Towson Baltimore If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Sociel Security Number Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□M 2√7 F Deys 217-22-1750 91 Yrs Director APR 18, 1908 Maryland Usuel Residence of Decedent show 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Director Ellicott City 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 23a 2913 Pinewick Road 21042-2205 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 😿 No by Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "na any Injury or other traumatic aven." Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dix Irene Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) John W. Burgoyne/son 2913 Pinewick Rd. Ellicott City, MD21042 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 Cremetion 3 ☐ Removal from State Other (Specify) 4 Donetion Metro Crematory, Inc. 11/30/99 Baltimore, MD duneral Service Lice Cremation Society of Maryland, Inc. Edward A. Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Final CANCER Lon disease or condition resulting in death) RAMS Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as e consequence of) Physician/Medical Due to (or as e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings avelleble prior to completion of ceuse of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours effer death. Funeral Director: After this certifics etely filled in by the funeral director, Be 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No Certification: To 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending 1 Neturel 1 Tes 2 No 2 Accident Investigation To the Hospital or Atter within 24 hours efter dea To the Funeral Director completely filled in by the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner steted. 29a. Certifier Medical

29d. Date signed (Month, Dey, Yeer) November 29, 1999

25205

N. Charles St. Bolto, md. 2120x

npleted cause of beath (Item 23e) (Type, Print)

6701 32. Registrar's Signature

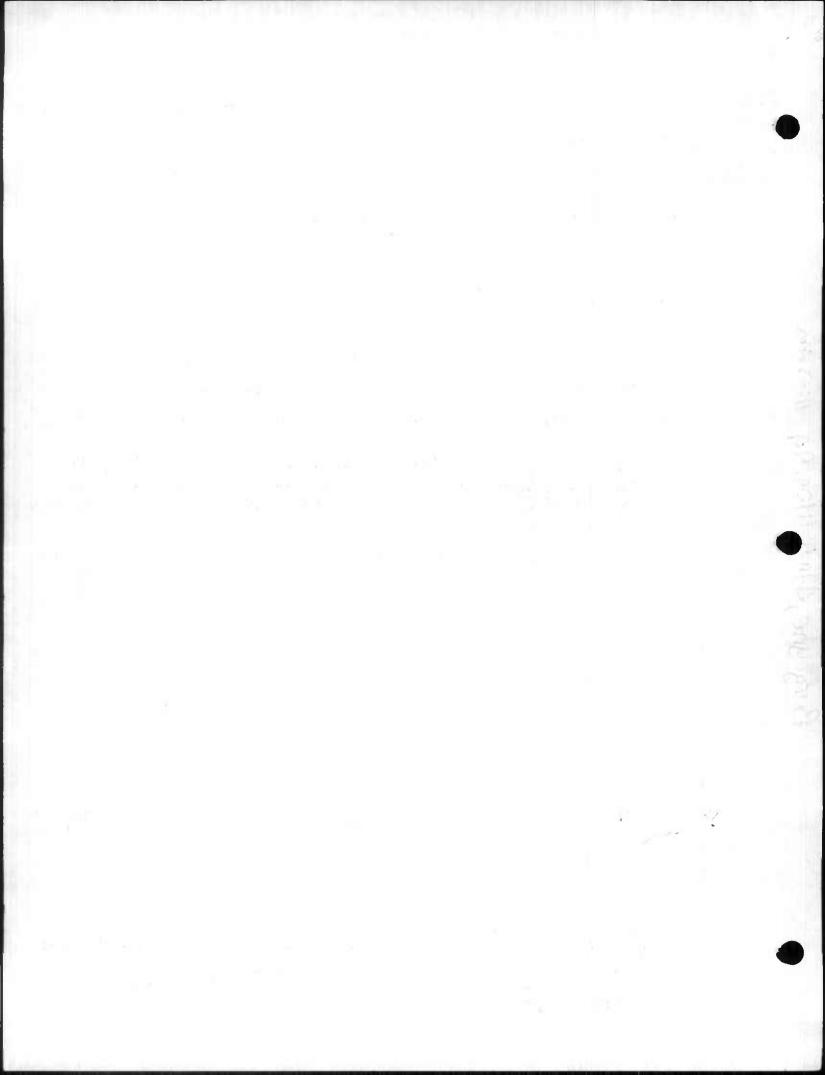
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Registrar

29b. Signature and title of certifier

DHMH 16 Rev 6/95

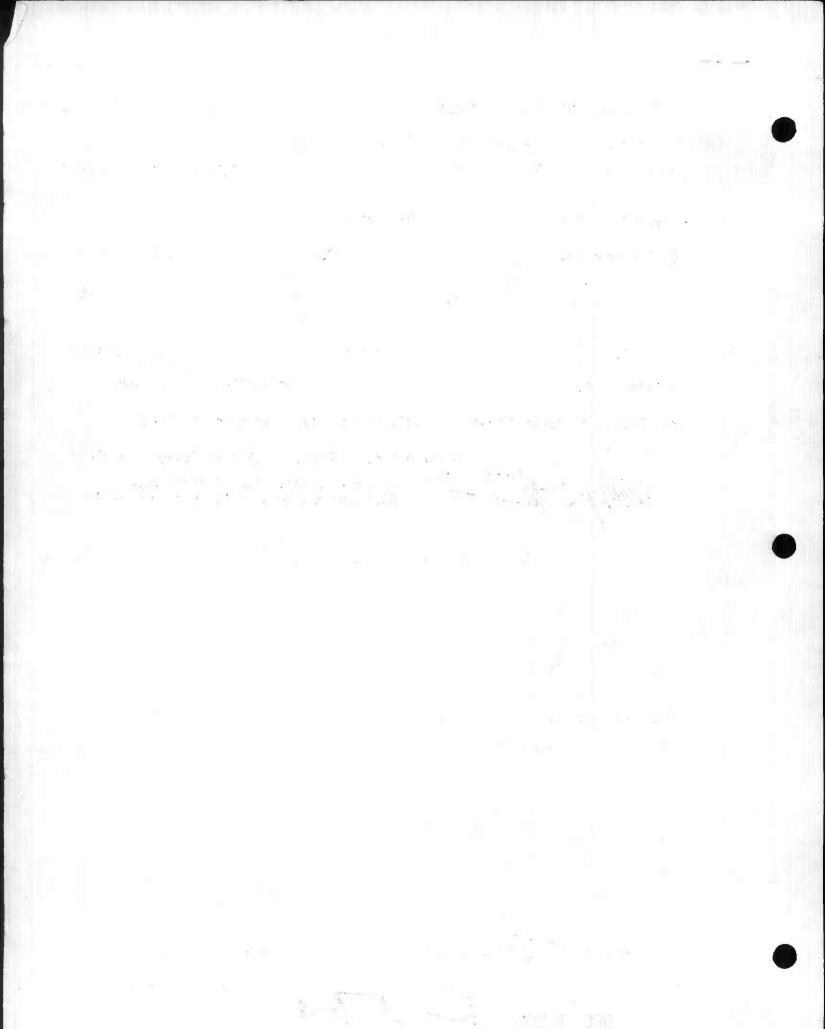
Division of Vital Records,



	Please Type or Prin State of Ma	aryland / Dep	artment of H	lealth and M			37789	
		Ce	ertificate of	Death	Reg.	No.		
Physician	Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year 3. Time of Dea						
/Medical		aker		th City T	Novemb	er 30 1		
Examiner	4a Fecility Name (If not institution, give street end number)	.71 -	_	4b. City, Town, or Lo	cation of Deeth	4c. County of D	-,	
	5. Social Security Number 6. Sex 7. Ag	e (In yrs. lest birthday	If Under 1 Year	Kosed A	8. Date of Righ	DAII	MORE Birthplace (State or Foreign	
Funeral Director	5. Social Security Number 0 6. Sex 7.749 229-18-8703 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You July 10,	1920	Birthplace (State or Foreign Country) Virginia	
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Mar. Fed ah	Maryland N/A	Bal	timore				1 X Yes 2 □ No	
irec	10e. Street end Number		10f. Zip Code		10g	Citizen of Whet	Country?	
al D	1035 Hignet Way		2120	15		United	States	
be filed within 72 hours effer death with the Maryland tel Hygiene. d other than "natural", or items 23a or 28a-f ahow event, the Medical Examinet must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Detes:		. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 No	dispanic Origin? (Spean, Mexican, Puerto I	ocify Yes or No- Rican, etc.)	14. Raca - A Bleck, V Specify:	merican Indian, thite, etc. White	
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flied within 72 ho Hygiene. wher then "nature ant, in Medical	(Specify only highest grade completed)	(Give	e kind of work done of DO NOT use retired	during most of workli	ng		9 H - 18	
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2 should and Men is marke numatic	19e. Informent's Neme/Reletionship (Type, Print)			and Number or Rura			e, Zip Code)	
りもとき	Mrs. Rosina J. Baker / Wife		Hignet W	-	more, MD			
of He of He	20a. Method of Disposition 1 □ Buriel 2 DMCremation 3 □ Removal from Stete		position (Name of ematory or other place	1 -		c. Location - City		
	4 □ Donation 5 □ Other (Specify)	Hilltop S	Service Co	1 -	/2/99 Tov	vson, Ma	ryland	
permit. Pag Department Important: It any Injury o	21. Signature of Europe Service Licenses 1 mothy		22. Name and Addre Conard J. 305 Harfo	Ruck, In	c. Funera	al Home e, MD 21	214	
Physician	23a. Part. Enter the chease, or comblications that caused shock, or heart failure. List only one cause on each lin						Approximete Interval Between Onset and Death	
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	ROVAS C Due to (or as a conse		Accide	nT		9 Days	
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sician: The law certificate has b lirector, page 2 s					1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No	
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	29a. Certifier (Check only one) Certifying Physician: To the best of the best	f examination and/or in						
within To th comp	29b. Signature end title of cartifier		29c. Licens				lonth, Day, Year)	
CX	30. Name and address of person who chapted cause of d	eeth (Item 23e) (Type	(, Print)	40819	a d	ovemb	ee 30 199 yland 2123	
State	DR. MARCC ZAMORA 9000 31. Dete filed (Month, Day, Year) 32. Registra	O FRANKII		E DR. B	AlTimor	E, MAR	yland 2123	
Registrar	DEC 3 1999 A	eners 1	U DUR	ALL Y				

DHMH 16 Rav 6/95

DEC



Please Type or Print In Black Indeiible Ink. Assure All Copies Are Legible. AMEND: TTEMS; #23 PART 27, 28A-F PER Certificate of Death 99 Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Deeth Month Physician 23, Judith Marie Byers NOV 1999 1:23 PM Medical 4a Far Ty Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5 moner 110 Cherrydell Road Catonsville Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) Funeral Months Days Yrs 45 Director 214-66-6882 New Jersev Usual Residence of Decedent with the Maryland ahow 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahov the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 110 Cherrydell Road 21228 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after. Hygiene. other than "natural", or ite 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider 12 Day Care permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any Injury or other traumatic avant. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 8 William Alfred Byers Eleanor Ann O'Neil 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Welkner / sister 706 Hunter Way Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Lakeview Mmorial Park 11/29/99 Cinnaminson, 21. Signature of Funeral Service License Max Reff MacNabb Funeral Home, P.A. George E. MacNabb Frederick Road Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical ACUTE ALCOHOL INTOXICATION Immediata Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, à 24b. Ware eutopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed page 2 s P. C

25. Was case refarred to medical axaminer?

3 Suicide

29a. Certifie

4 Homicide

(Check only

1 X Yas 2 □ No

21201

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 28a. Data of Injury F (Month Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending investigation UNKNOWN 1 Yes 2 Ne 11-23-99

Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 28d. Describe how injury occurred Subject

26. Place of Death (Check only one)

INGESTED ALCOHOL

Baltimore, MD

1X Yas 2 No

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) HOME 1 Certifying Privale

281. Location (Street and Number of Buyal Route Number 1 RD City or Town, State) IIU Cherrydell RD RD. BALTIMORE CO. MD

29b. Signa

6 ☐ Could not be

In: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

O.C.M.E. who completed cause of death (item 23s) (Type, Print)

November 24, 1999

State Registrar

8

Certification: To

edicai

31. Data filed (Month) 32. Registrar's Signature 1999

111 Penn Street sacks

of Vital

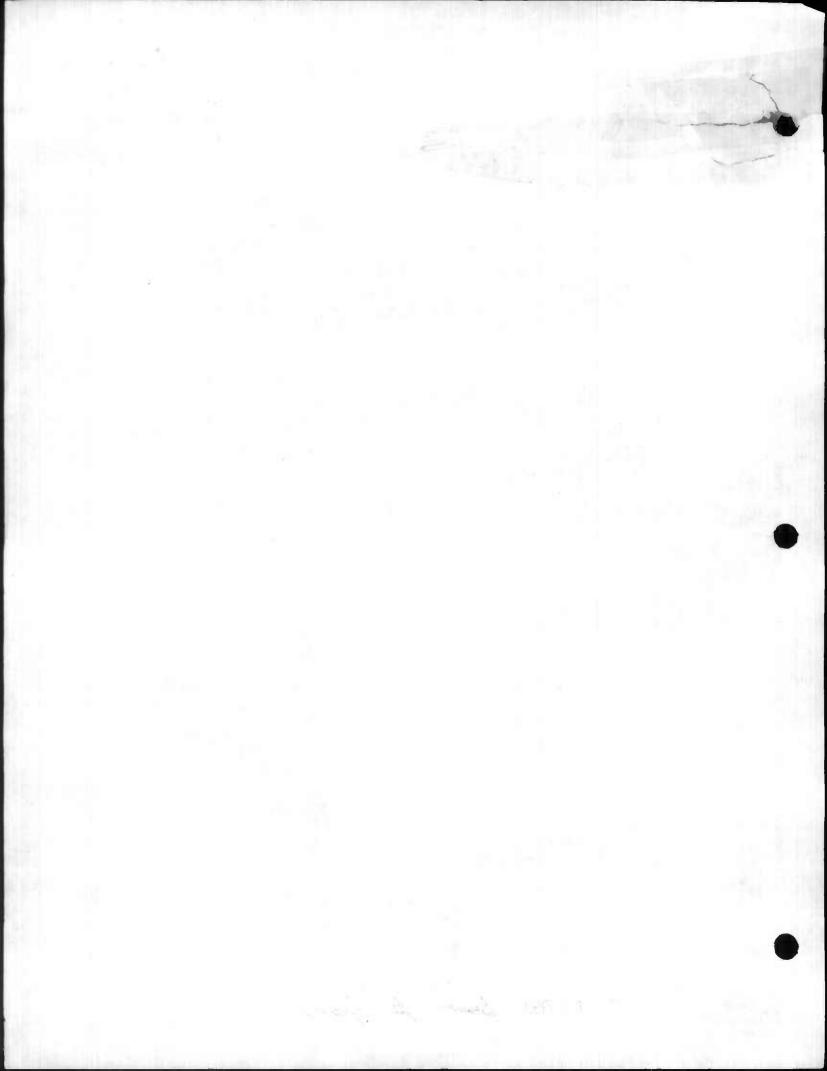
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n 24 hours after death.

• Funeral Director: Al

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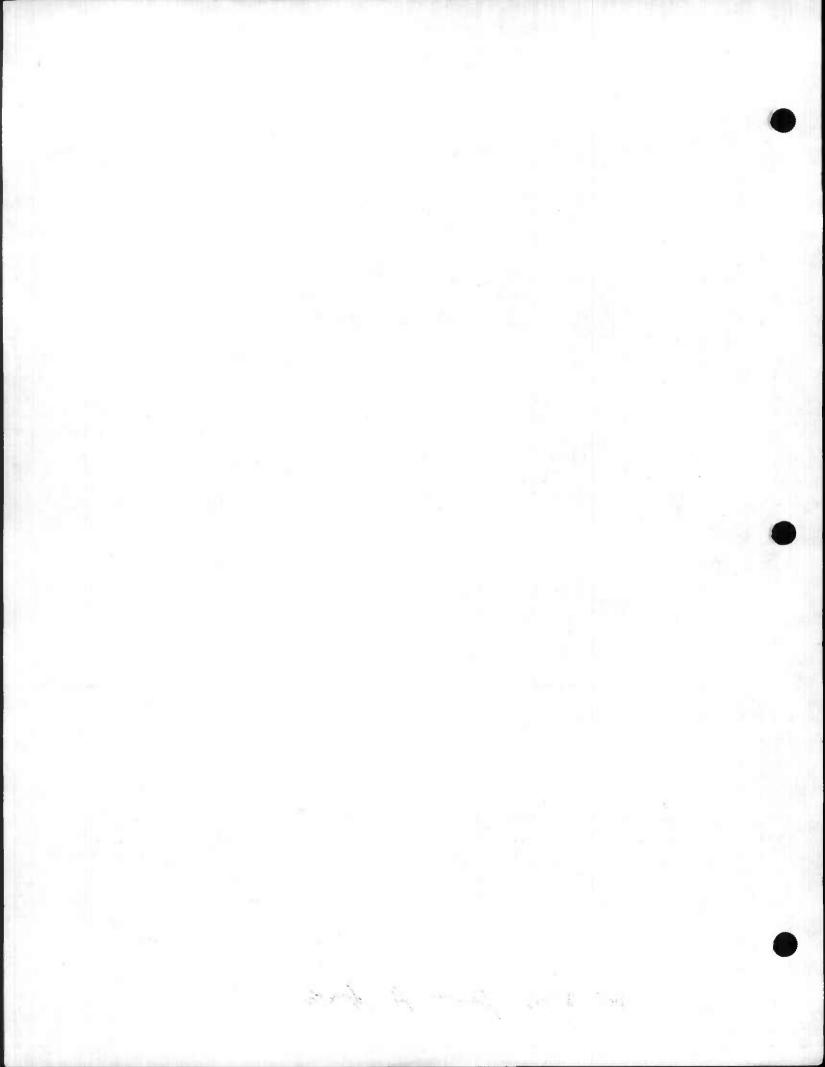
death.



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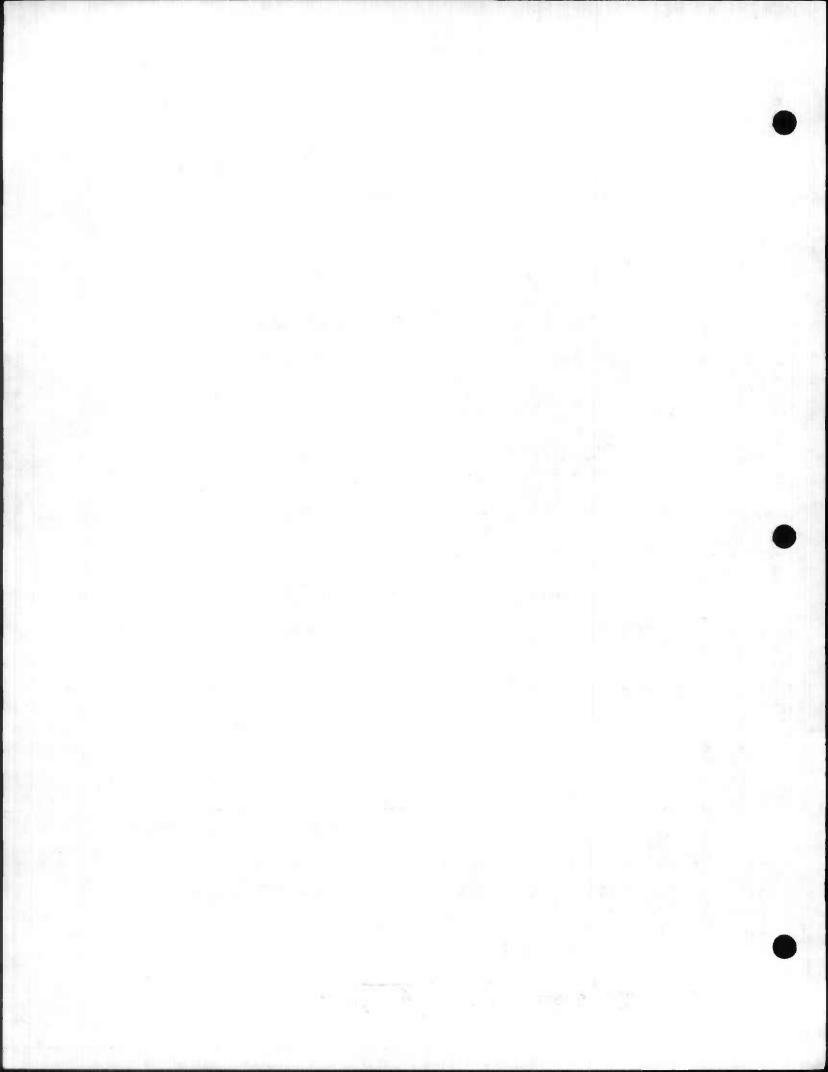
State of Maryland / Department of Health and Mental Hygiene

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Funeral Director		□M 2□F	20 Yrs.	Months		lin. (Month, D	14,1979	Birthplace (State or Foreign Country) MARYLAND
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ind Age field of other event, if	17. Father's Nama (First, Middla, Last)		01001		Name (First, Middle		6)	
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BE 10 TO 10 BE 1	19e. Informent's Neme/Relationship ((Street and Number or			
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diffillore, mit. Pages 1 at partment of Hea portsent: If Ihem: y Injury or othe	1 Suriel 2 ☐ Crametion 3 ☐	Removal from Stete	cemetery, cr	ematory or ot	her place)			
of the parties of the	4 ☐ Ponetion 5 ☐ Other (Specify 21. Signature of Funerel Service Licen	التأليا (الماليا		ILL C	EM. DEC.	4,1999	GlenBU	RNIE, MD.
Physician /Medical Examiner	23d. Pert1. Enter the diseese, or companies, or heart feilure. List only immediate Cause (Finet disease or condition resulting in deeth)	. Stub h		nter the mode	E. PRESTO	ON STRE	ET BAL	Approximete triterval Between Onset and Death
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fending Phy death. tor: Affer this the funeral	27. Menner of Deeth 1 Naturel 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 25	Sc. Injury at Work?	_ /	how injury occurr	,
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Para de Para de la Companya de la Co	4 5 Homicide determined	Gry or To	18f. Location (Street and Number or Rural Route Number, City or Town, State) 1800 BUK N. Nurkam St					
he Hospi in 24 hou he Funer pletely fill	29a. Cartifier 1 Certifying Ph	vsician: To the best of my kno liner: On the basis of examine						
ithin 2 mple	29b. Signatura and title of certifiar	end menner steted.		290	License number		29d. Date sinner	i (Month, Day, Year)
F 3 F 8		161		230	OCME			ER 27, 1999
	30 Name and artifrace of narrow	completed cause of death floor	n 23e) /T	a Drine)				
5	30. Name end address of person with a	7			not Dales	morro Ma	arland or	201
State	04 Date (1) 1 (1) 1 (1) 1 (1)	999 32. Registrar's Sign		9 1	get, Balti	more, Mai	rATGIN 51	LZUI
Registrar	550 3	ارداد		17			2	

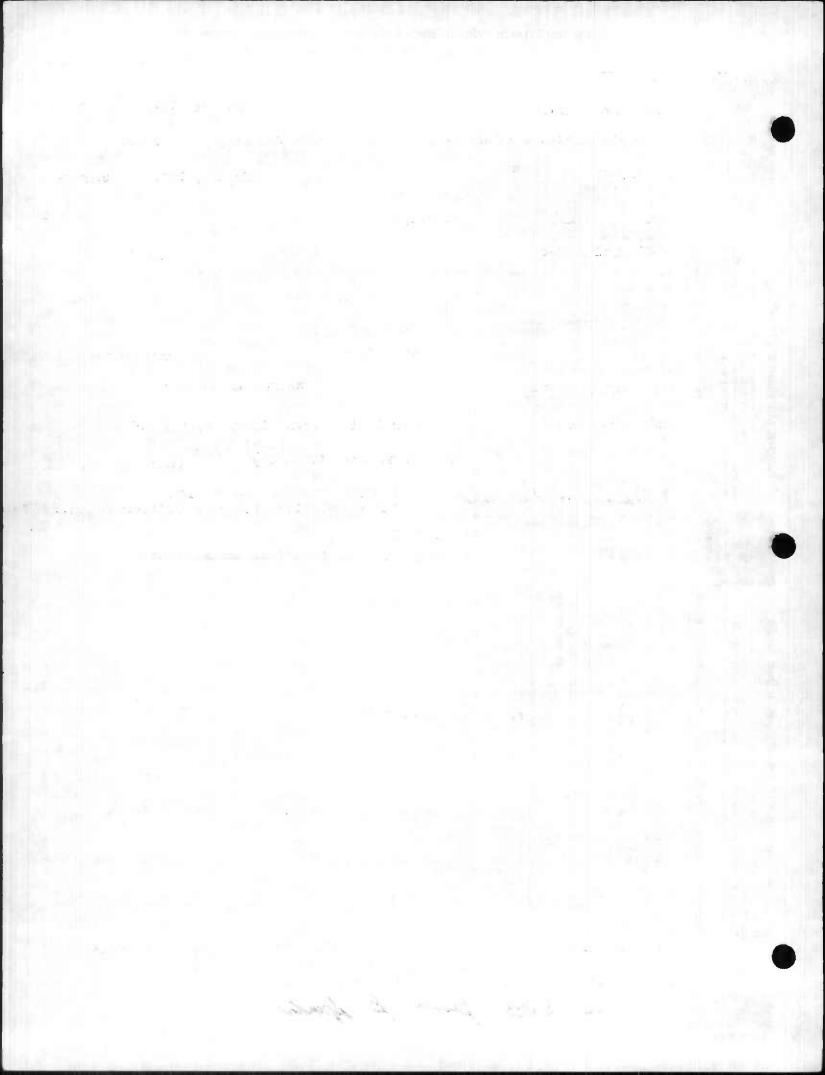


DDG State of Maryland / Department of Health and Mental Hygiene Q Q 27702 DHANNA_CHAHAL.

Physician	1. Decedent's Nama (First, Middle, Last) Dhanna Singh Chaha	1		Day Yaar 3. Tima of Deat 30, 1999 1133 AM					
/Medical Examiner	4a Facility Name (If not institution, give street and number) 631 RAPPOLLA STREET		4c. County of Death N/A						
Funeral Director	5. Social Security Number 215-06-7352 6. Sex 1MM 2 F 7. Age (In yrs. last birthday, 46 Yrs.) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or For Country) 153 India					
of show fied at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD N / A Balti			10d. Inside City Lin 1∭ Yas 2 □					
23e or 28e-fe	10e. Street and Number 631 Rappolla Street	101. Zip Code 21224	10g.	Citizen of What Country?					
natural, or harms 23s or 28s-4 show disal Examiner must be notified at sted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forçes? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☼ No Specify:	Specify Yes or No- rto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, atc. SpecifyAsian Indian					
H P	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) hier	orking 16b	. Kind of Business/Industry Restaurant					
	17. Father's Name (First, Middle, Last) Ranjit Singh Chahal	16. Mother's Na	uma (First, Middle, Maid sant Kaul	den Sumama)					
Health and Mental Phealth and Mental Phealth and Mental Phealth are the control of the control o	19a. Informant's Name/Ralationship (Type, Print) 19b. Mail	ling Address (Street and Number or R Rappolla St.,							
Department of Health Important: If Health Important: If Health any Injury or other then 27 and 16.00 and 1		osition (Nama of ematory or other place) ematory, Inc. 12/		Location - City or Town, State					
Depart Import eny Inj 2006	21. Signature of Purperal Service Licenseer 2 Land A Justical Licenseer 2 Edward A. Gegorchik 2	2 Nama and Addrass of Facility Cremation Soci 299 Frederick	ety of Ma Rd. Balt:	aryland, Inc. imore, MD 21228					
Medical Examiner	Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, If any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect of the conditions). Due to (or as a consect of the consect	induced (Six induced of):							
d by the attendir	Part It. Other algnificant conditions contributing to death but not resulting in the u	underlying cause given in Part t.	23b. Did tobac	co use contributa to the cause of dec					
been signe should be c			24a. Was an au	stopsy 24b. Were autopsy finding					
certificate has rector, paga 2 Be Comp	25. Was case referred to medicat	26. Place of De	path (Check only one)	2 No 1 Yes 2 No					
this certific ral director. To Be	examiner? 100 Hospital: 1 Inpatient 2 ER/Outpatie		Homa 5 Residence						
After funer funer	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, st	NOWN 1□ Yes ⊅Q No							
ctor: y the	4 Homicide building, etc. (Specify) HOME BALTIMORE, MD								
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. Medical Certification: To Be Com		th occurred at the time, date and place	e, and due to tha cause	e(s) and mannar as stated.					



Physician (Madiea)		it a regime		fle, Last)								te of Death	Dey	Yeer	3. Tima of De
/Medical	Anna Lee Cline										Nov	. 24,	1999	1001	10:15p
Examiner	4e Fecility Neme (If not institution, give street end number) St. Agnes Nursing & Rehab. Ctr.								4b. City, Town, or Location of Deeth 4c. County of Death						
<u> </u>								. If I lands	r 1 Yaar	Ellicott	-		Howai		
rector	5. Sociel Se 375-2 Usuel Resid	4-10	61	6. Sex	M 2∭7 F	7. Age (in yr	rs. last birthda Yrs.	Months			. (M	te of Birth onth, Day,			laca (Stete or F try) ICSSCC
8 m	10e. Stata	derica or	10b. County	у		10c. 0	City, Town or I	Location						10	Od. Insida City
1 of	MD.		Howar	rd		El	.kridge	9							1 ☐ Yes 2
Director	10e. Street								p Code			10	g. Citizen of V	Vhet Coun	itry?
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by	3 Elwic		ed 2 Mar 4 Divorced		1 Yas If Yes, Give Yaer or De	е		1□ Yes	≱ ∑ No	Specify:			Specify	· W	hite
Completed		(Speci	15. Deceder	nt's Educa	ition completed)		16e. Dec	cedent's Usu	ei Occup	pation during most of wo	rking	1	16b. Kind of Bu	usiness/Ind	dustry
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T			me/Reletions				19b. Ma	ailing Addres	s (Stree	t and Number or Fi				Stete, Zip	Code)
r traumatic event, I			ne, so										Md. 210		
redto	20a. Metho	d of Disp	osition			20b					Date	2	20c. Location -		wn, Stete
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any injury o once.			neral Service							ess of Fecility			naure.	1 9 11	u.
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edical miner	Immediete disaase or resulting in	Ceuse (F	Final	e	cause on ea	C	BLE CARC	TNUMA	P	uneral n Knoll ing, such es cardia	c or resp	aka.	S.J.		Approximate Interval Betwee Onsel and Dec
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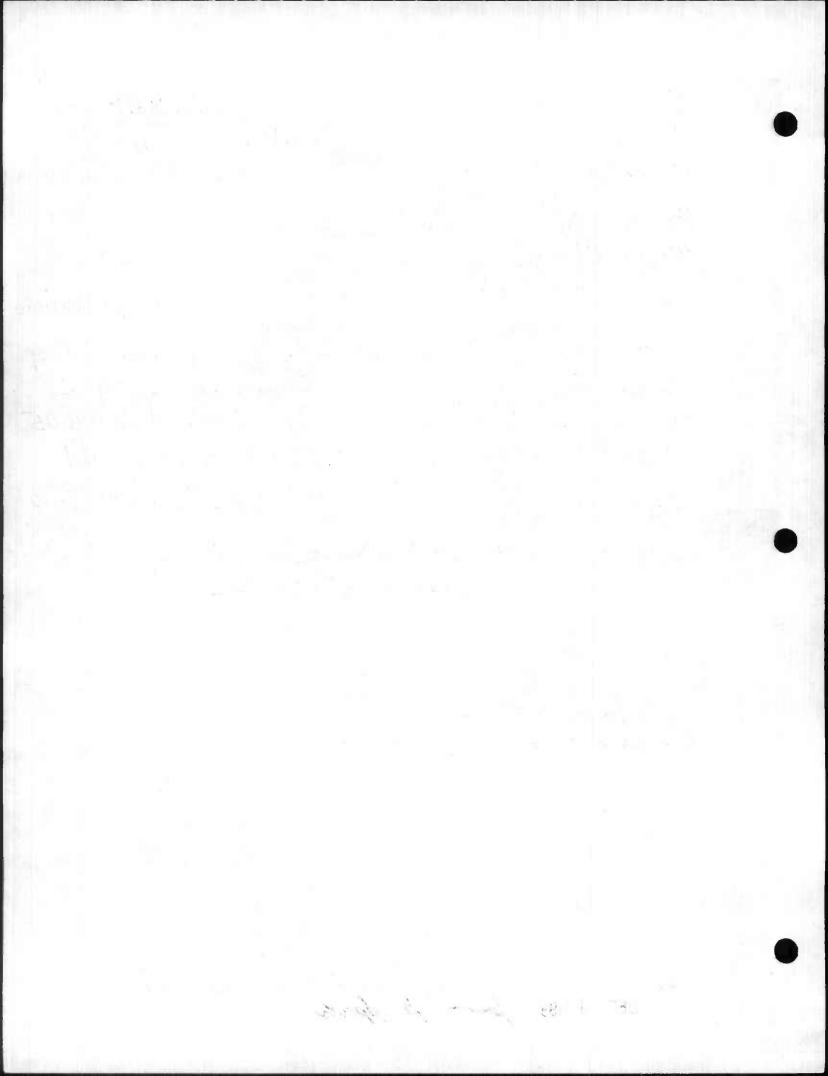
State Registrar

DHMH 16 Rev 6/95

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32. Aggistrar's Signature



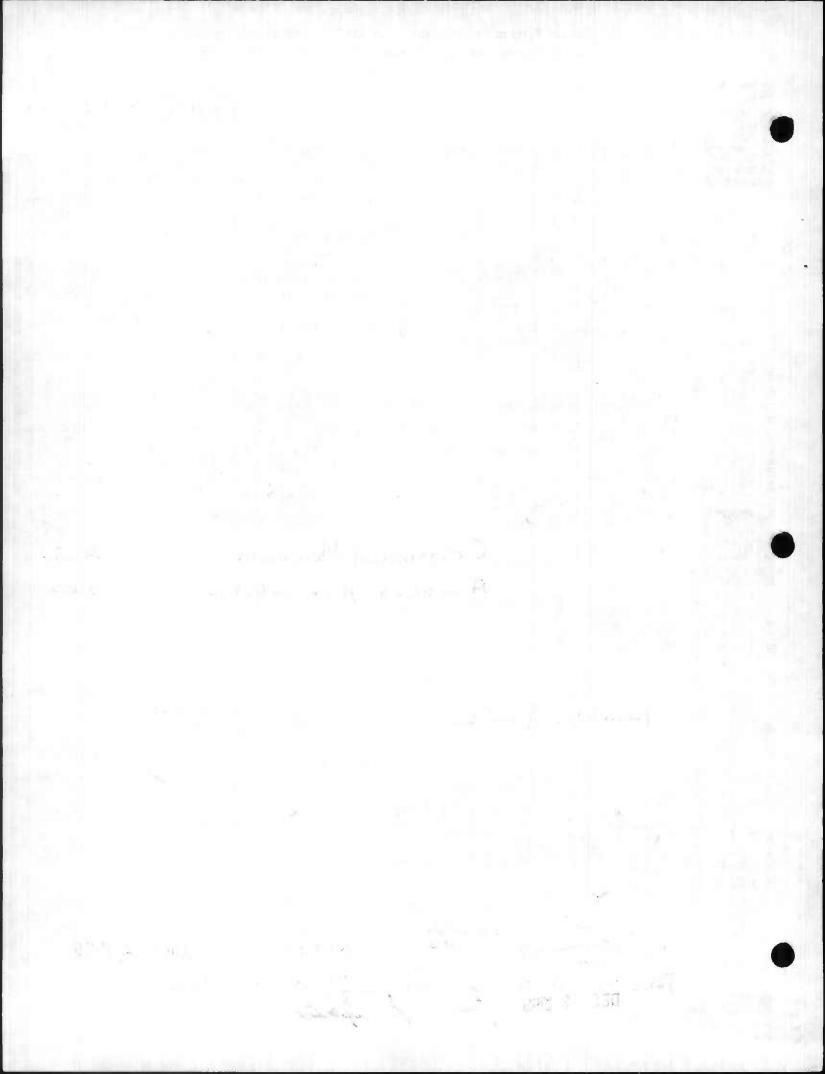
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 7.35 pm aneccia December Tandora /Medical 4c. County of Deeth Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Multi-Medi 5. Sociel Security Number 700 Vark Road
Age (In Irs. last birthdey) If Under 1 Yeer Himore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Callenter 6. Sex 9. Birthplece (State or Foreign Country) **Funeral** Months Deys 10 M 20 F 217-4/8-1648 Usuel Residence of Decedent 46 Yrs. Maryland July 6,195 Director filed within 72 hours after death with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic evant, the Medical Examiner must be notified at 1 TYes 2 No Director laryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any injury or other traumatic event. The USA 14. Race - American Indian, 2122 Funeral aad Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: Black Specify Ś 3 Widowed 4 Pipivorced Completed Decedent's Usuel Occupation
 (Give kInd of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Health nIA Assitant 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be rank Brown Dell Beatrice 19b. Mailing Address (Street end Number or Rurel Route Number, City of Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Doughter 920 Ba 20e. Method of Disposition HI more 20c. Location - City or Town, Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date December 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) oodlawn 22. Name end Address of Fecility Doughss Funeral Services
1701 me Cullah Street, Baltimore, m 221217 Funeral Service 21. Signeture of Funerel Service Licenses Part i. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical fmmediate Ceuse (Finel Month diseese or condition resulting in deeth) Examiner Examiner DVMCED years attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ed by the atter Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. 23b. Did tobacco use contribute to the cause of death? B, and C signed by 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? page 2 should Completed 24e. Wes en eutopsy performed? peen After this certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medical examiner? funeral director, Be 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 I Homicide 29a. Certifier (Check only one) in Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. edicai completely Attendisa 29b. Signature & 29c. License number 29d. Dete signed (Month, Dey, Year) 0 MD 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Mid 4e/Race 2/2 31. Dete filed (Man) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 3779

					C	ertifica	te of	Death		Reg. No.))	1190
	Decedent's Name (First, Middle, Last)								2. Dete of D	eeth		3. Time of Death
Physician	Vernon E. Dver									Month Day Ye ecember 1, 1999		12:28pm
/Medical Examiner	A Control of the second of the							4b. City, Town, o	or Location of Dea		y of Death	IZ.ZOPIII
Examiner	North	Arundel H	Josnital				0	Glen Bur	nie	Anne	Aruno	1-1
Funeral	5. Social Security N			7. Age (In yrs.	. last birthd	av) If Und	er 1 Year					place (Stete or Foreign
Funeral Director	283-40-60	748	∑ M 2□ F	55	Yrs	Months	Days	Hours Mi	n. (Month, D	4,1944		cucky
P .	Usual Residence of	10b. County		10c Ci	ity, Town or	r Location	-				1	Od. Inside City Limits
erylar e thow												1 Yes 2 No
the Men r 28e-f eh motified	MD	Anne Ar	unde1	Gar	mbri1							
with the Me to or 28a-f e be noutling	10e. Street and Nu						ip Code			10g. Citizen of	What Cour	ilry?
ra 123 95	1083 Snov	A HITT Ta					.054	-		USA		
21215-0020 within 72 hours effer deeth with the Menyland ene. The "returnal", or ferme 23e or 28e-4 show the Medical Examiner must be notified at ampleted by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed	ed 2 Merried 4 Divorced	Armed Fo		1			Hispanic Origin? pan, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		ice - Americ ack, While, ify: Whi	elc.
JER 121215-0020 ad within 72 hours of yoldens yoldens of the Maddel Even to Maddel Even Completed by F	(Spec	15. Decedent's Enify only highest gra	ducation ade completed) College (1	-4or 5+)	(G	ecedent's Us live kind of w e. DO NOT	rork done	during most of w	vorking	16b. Kind of I	Business/Ind	Justry
D 22 Barran Mo	12			1,000	Enl:	isted				U.S.	Army	,
aryland 2 should be filed marked other umatic event, is	17. Father's Name	First, Middle, Last,)					18. Mother's N	eme (First, Middl	e, Maiden Sume	me)	
Maryland 12 should be file 12 should be file 12 should be file 14 should be file 15 should be file 16	George Dy	yer						Liza I	ucille 1	Burk		
Mary d 2 sho th end N 7 le me treume	19a. Informant's Na	me/Relationship (Type, Print)		19b. M	aiting Addres	ss (Stree	t end Number or	Rural Route Num	ber, City or Town	n, Stete, Zip	Code)
- 2=2	Young H.	Dyer - W	ife		1083	3 Snow	Hil	1 Lane,	Gambril	ls, MD	21054	
7 = 955		osition Cremation 3 5 Other (Specif		State		sposition (M cremetory or Vete			Date 12/6	20c. Location		
Baltimo	21. Signature of Fu			1/1	/	22. Name a Harde	and Addre	ess of Facility Funeral	Home, P	.A.		
	· vai	ner [000	now					, Annap		214	
Physician /Medical	23a. Part1. Enter ti shock, or hea Immediate Cause (Final	one cause on e	ach line.	in. Do nor		P-	The second	ac or respiratory	arresi,		Approximate Intervat Between Onset and Death
Examiner	disease or condition resulting in death)	n	a +.	Due to (or as a con	sequence of	71 1):	UN	acce of		1	788
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68760, fifficate be executed graphysician and as the burish-transit fedical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of): Due to (or as a consequence of):											
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18 5 4 5 0 D	that initiated events resulting in death) Last Due to (or as a consequence of):											
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O 9 9 9 9	Part II. Other signif	cant conditions o	ontributing to de	eath but not res	sulting in th	e underlying	cause gi	ven in Part I.	23b. Di	d tobacco usa c	ontributa te	o the causa of death?
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of Vital Records, P.O. Box Physician: The law requires that the death ce this certificate has been signed by the estendirel rel director, page 2 should be deteched for use TO Be Completed by PhysicianA	Status port anysoplanty 1988, 89. CABS							CABGI	990 24a. Wa	s an autopsy formed?	av	ere autopsy lindings allable prior to impletion of cause death?
Com Com	\mathcal{D}_{a}	0-	Ples.	0, 7				′	10	Yes 200 No	1[☐Yes 2☐No
Vital I victor: The confiltents rector, per	25. Was case refe	red to medical	ues a	May 1	MAL	ase	` _	26. Place of D	eath (Check only	one)		
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On of stage of the	27. Manner of Deat	1	28a. Dete	of tniury	28b. Time	e of	28c. Inju Wo		7	how injury occi		,,
ding language of tuner	1 Matural 2 Accident	5 Pending investigation		h, Dey Year)	Injur	ny M		ork?]Yes 2□No				
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours effer death. To the Funeral Director: After this cartificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification: To Be Completed by	3 Suicide 4 Homicide	6 Could not b determined	200. F1000	of Injury - At h	nome, larm,	street, facto	ory, office		281. Location City or T	(Street and Nun own, Stete)	nber or Rure	el Route Number,
e Hosplu n 24 hourn e Funere sistely fills	29a. Certifier (Check only one)	Certifying Ph	niner: On the ba	best of my kno asis of examine ner stated.	owledge, de etion and/or	eath occurre r investigatio	d at the ti	ime, date and pla opinion, deeth oc	ce, and due to th curred al the time	e cause(s) end r a, dete end place	nanner es s	tated. the cause(s)
Neithir Neithi	29b. Signature and	title of certifier				2	9c. Licen:	se number		29d. Date sign	ed (Month,	Day, Year)
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10	30. Name and addr					pe, Print)	0 1	01	200	- []	100 0	Md.
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State	31. Date filed (Mon	h, Day, Year)		egistrar's Signi	ature	Kar	11	,				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23a perPHYG778 12/03/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:40 PM Zella November /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner of Baltimore Baltimore Sinai Hospital N/A 8. Date of Birth (10) 10.08 1910 If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign
Country) **Funeral** Days Months Hours Min. 1 M XXF 216-22-4068 Arkansas Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limite r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Baltimore Yes 2 No N/A Md. Director 10e Street and Number 10g. Citizen of Whet Country? 10f Zin Code death with 21215 USA 5429 Jonquil Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yaar or Datas: 14. Rece - American Indian, Black, White, atc. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) t 1. Marital Status ified within 72 hours after all Hygiene. 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Widowed 4 □ Divorced py Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12 th College (1-4or 5+) Domestic Housewife permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other th
eny injury or other traumatic event, the 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surnama) Walter T. Matlock Arilla Dickerson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5429 Jonquil Ave. Balto., Md. 21215 19e. Informent's Neme/Reletionship (Type, Print)
Carrie Matlock (Sister) Carrie Matlock 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition 11/21/99 Catonsville, Md.21229 1 ☐ Buriei 2 X remetion 3 ☐ Removal from Stata Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral Service 21. Signature of Funeral Service Licenses 13. 5502 Winner Ave. Balto., Md. 21215 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Ceuse (Final disaasa or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner Renal Insufficiency that the death certificate be executed ng physician and as the bunal-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): HYPERTHYROIDISM Physician/Medical Due to (or as a consequence of) esn signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? Completed HyperthyroidisM. certificate has 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: D⊠ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes > No After this funeral 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred Certification: or Attending Naturat 5 Pending investigation 24 hours after death.
 Funeral Director: Aftereity filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide Hospital edical 🍽 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner es steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 2401 West Belvedere Avenue Battmare, MD2126 Ba Himore

Registrar **DHMH 16 Rev 6/95**

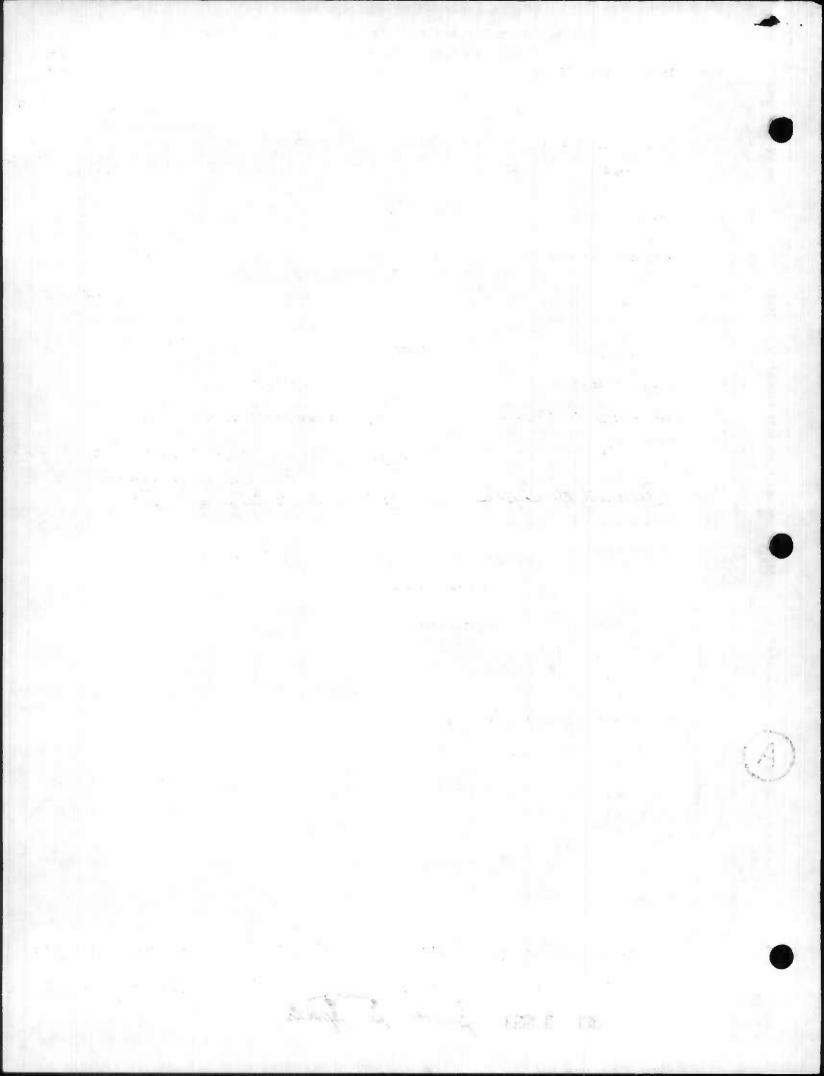
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32. Registrary Signature

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31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2 55 pm ROBERT FLETCHER NOVEMBER 1999 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death JOHNS HAPKINS BANNORE BALMMORE CITY BAYVIEW If Under 24 Hrs. If Linder 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 10 M 20 F 6 215-88-6261 3 Ma Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Baltimore NA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 365 arkton 21229 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 △Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married specify: Black 1 ☐ Yes 20 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Tank Elementary/Secondary (0-12) College (1-4or 5+) Tanker 2th grade NA Unver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) obsert hee Davis ula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4365 Street en (40, MG cher 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bullal 2 Cremation cemetery, crematory or other place) 3 Removal from State M9 4 □ Donation 5 □ Other (Specify) 22, Name and Address of Famil 21. Signature of Funeral Service License Da 140, Md DIM unbash Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death TWELVE Immediate Cause (Final BRAIN EDEMA HUNS disease or condition resulting in death) Due to (or as a consequence of): THREE GLIOBLASTOMA mula forme MANK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20 No Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

The lew requires that the death certificate be executed the burial-transit P.O. Box 68760. Physician/Medical 98 080 been signed by the a should be detached t Records, p Be Completed . page 2 certificata Division of Vitai Hospital or Attending Physician: Medical Certification: To this funeral After after death. completely filled in by

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

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filled within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

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or other tra

Department of Important: If any injury or

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Matural 2 Accident

3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD

29c. License number 29d. Date signed (Month, Day, Year) LE3-000 29, 1999. NOVEMBER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sums BANNONE M. LESNIAK HOPKINS RAYVIEW, 4940 EASTERN MD 31. Date filed (Month, Day, Year)

State Registrar

DEC 3 1999

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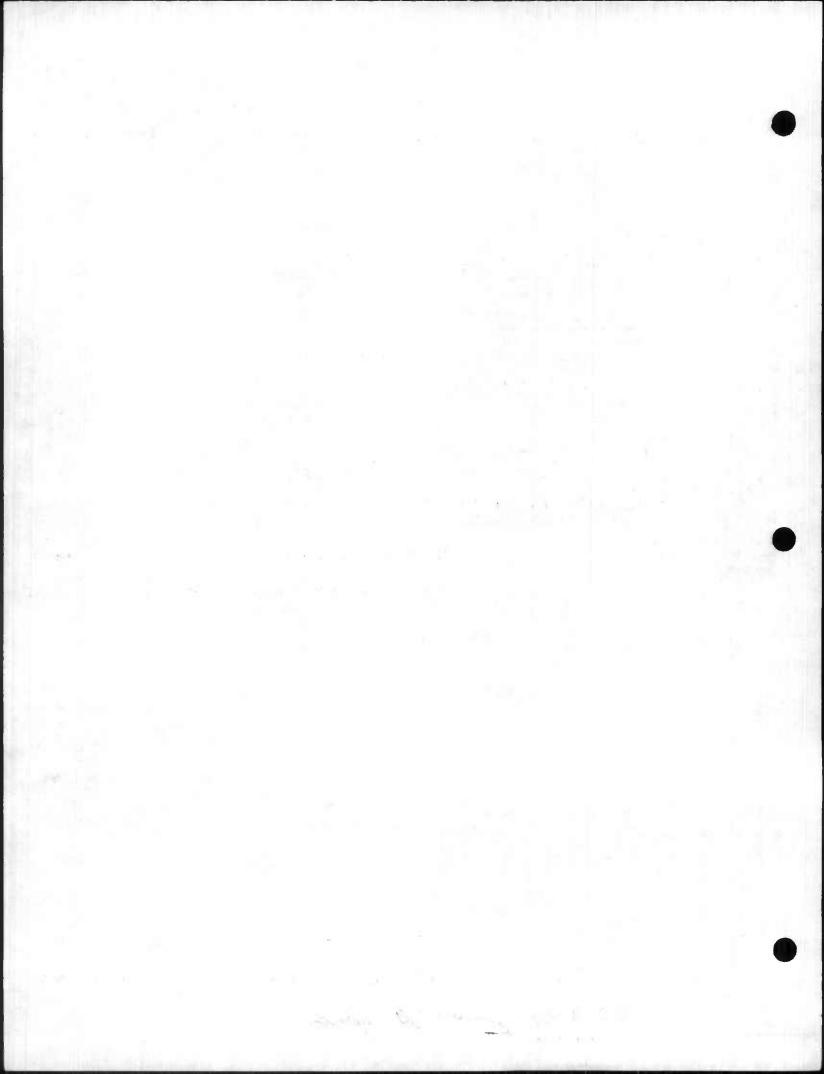
29b. Signature and title of certifier

32. Registrar's Signature

DHMH 16 Rev 6/95

24 hours a

within 2 ş



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Physician Chervl Foster December 1:45 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hedical Center Annapolis Anne Arundel Months Days Hours Min. March 28, 1957 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York Funeral 1□M 2ØF 216-70-3480 42 Director Usual Residence of Decedent 10a Steta 10b. County 10c. City, Town or Location tOd. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Mary land Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 223 Ferndale Road 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Nevar Married 2 Merried White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "as any injury or other traumatic event, in Mental page. Elementery/Secondery (0-12) College (1-4or 5+) Sr. Computer Scientist Department of Defence 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Jack H. Foster Sr. Betty A. Hubbard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Pauline 223 Ferndale Road Glen Burnie, MD 21061 Katauskas admin 20b. Place of Disposition (Name of cometery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 12/3/99 Baltimore, Maryland Metro Crematory Inc. 22 Name and Address of Facility
Stallings Funeral Home P.A. 21. Signature of Funeral Service Licensee 3111 Mountain Road Pasadena, MD 21122 Mit caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel LIME CANCER LYEARS disaasa or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificata be executed Sequentielly list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 be Yes 2 No 3 Probably 4 Unknown been signed l should be det Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? page 2 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical axeminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 200 Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No death. investigation hours after death uneral Director: / 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signatura and title of continue 29c. License number 29d. Date signed (Month, Day, Year) 16360

State Registrar 31. Dete filed (Month, Day, Year)

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32. Registrar's Signature

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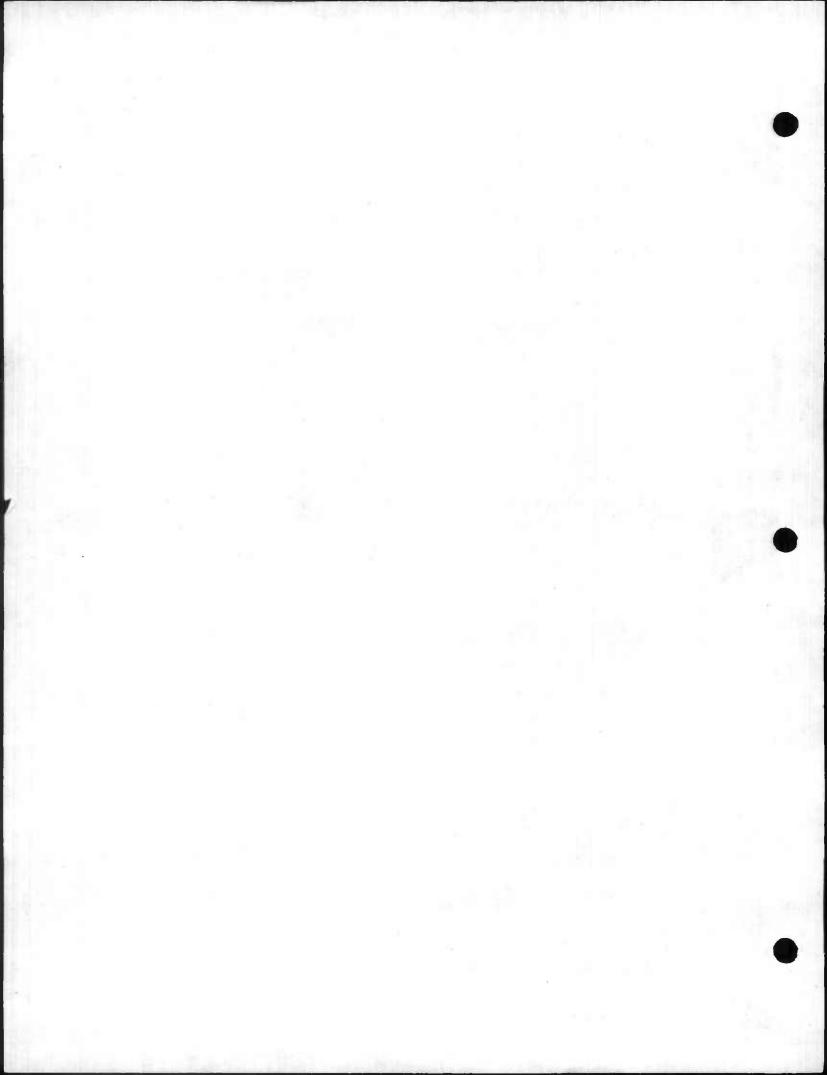
30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

Peter R. Graze, M.D.

Suite 300

nature & S. Sparks

900 Bestgate Road Annapolis, MD 21401



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#5 perFHG778 12/21/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Mary Judith Gibb 30, 1999 NOV 6:54 AM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center
5. Social Security Number 5284 6. Sex Baltimore Towson If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) Birthplace (State or Foreign Country) **Funeral** 1□M 🙀 🗆 F Days 59 Yrs. 408-68-5285 Director JULY 23, 1940 Tennessee Usual Residence of Decedent the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yes X No Ellicott City Howard Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 3582-B Church Road USA items 23a Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 9 1 ☐ Yes 2 No Spacify: White þ 3 ☐ Widowed 4 ☐ Divorced 'natural', 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry
Giftware 15. Decadant's Education (Specify only highest grade completed) 4 Collaga (1-4or 5+) marked other than Elamentary/Secondary (0-12) Manufacturer Sales Representative Injury or other traumatic event, 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Depertment of Haalth and Mental Important: If item 27 is marked of Horace Stubblefield Georgia Merryman 19a. Informant's Name/Retationship (Typa, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) Hugh I. Gibb, II/husband 3582-B Church Rd., Ellicott City, MD 21043 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata Metro Crematory, Inc. 12/01/99 Baltimore, MD 5 ☐ Othar (Specify) 4 Donation Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

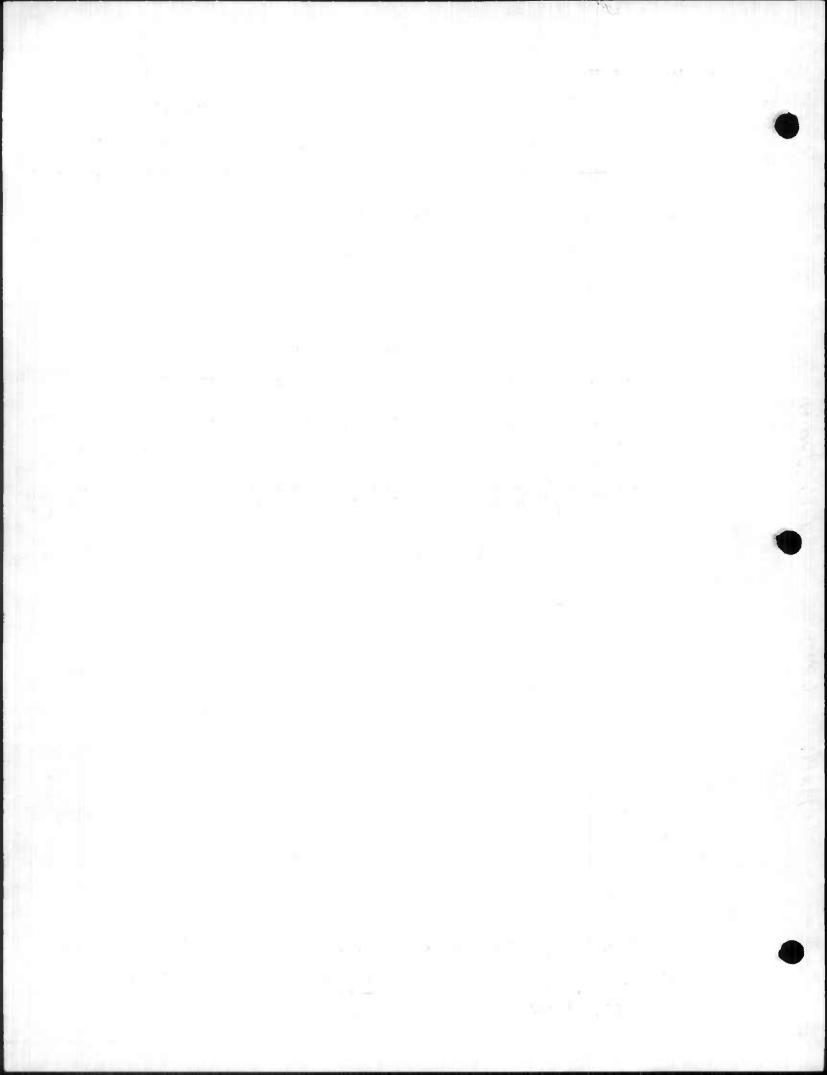
asa, 4-complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest,

Approximate 21. Signature of Fatheral Service Edward A. Onsat and Death Physiclan Immadiata Causa (Final CANCEY months disease or condition resulting in death) Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated events rasulting in death) Last pue Due to (or as a consaquence of): Box 68760. iding physician Dua to (or as a consequance of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings evellable prior to Completed 24a. Was an autopsy completion of cause of death? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medicat examinar? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No 10 27. Manner of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Division 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 I Homicida 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Cartifiar 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number Dasdas November 30, 1999 no 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) N. Charles St. Balts and 21204 G BME 6701 31. Date filed (Month 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

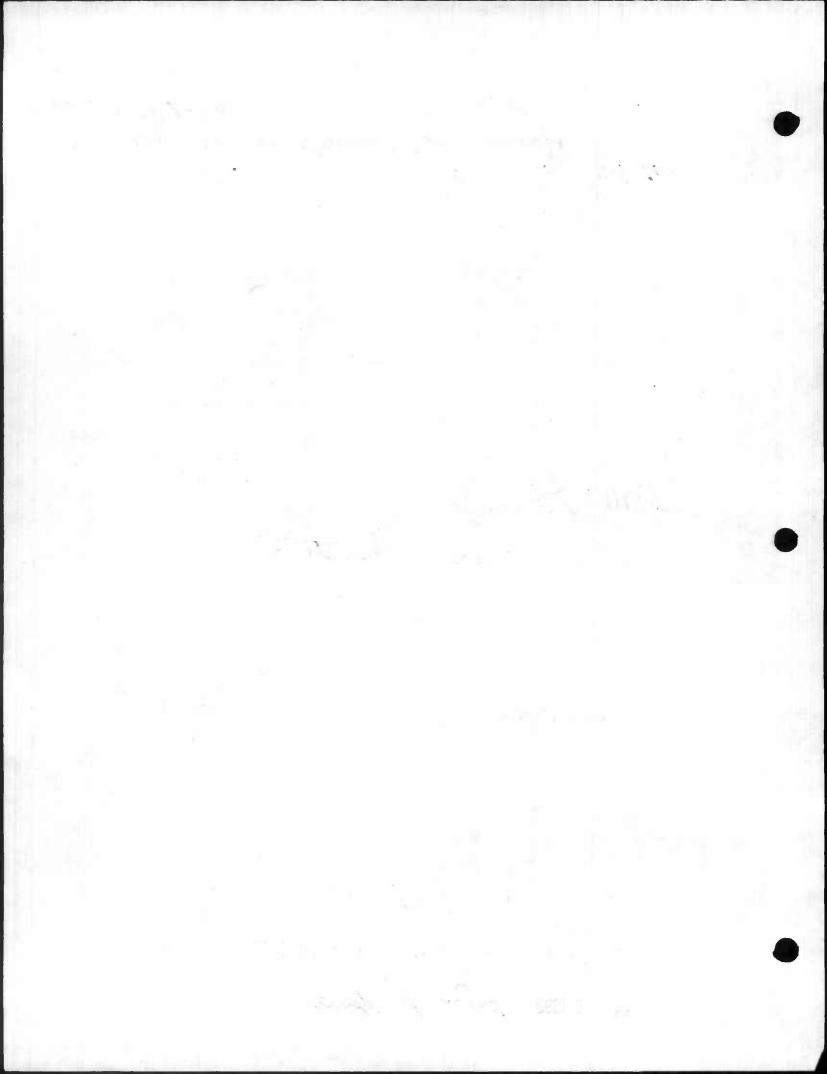


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gaithe Vov 2 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (Phot ins **Examiner** bia If Under 1 8. Date of Birth (Month, Day, Yea 3/27/1913 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Euneral** Days Hours 1 3M 2 F 6372 MARYLAND Director Residence of Decedent The Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD HOWARD COLUMBIA 1 ☐ Yes 2 No Director 28e-f 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code ò 8 21045 7110 MINSTREL WAY munt b Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Merried XX Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 20XNo Specify: WHITE ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry WASHINGTON Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) NATIONAL ZOO ZOOKEEPER 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill thent of Health and Mental Hants (If hem 27 is marked oth jury or other traumatic even Be GAITHER UNKNOWN (UNKNOWN) UNKNOWN 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7110 MINSTREL WAY COLUMBIA, MD 21045 BETTY GAITHER (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removef from State Department of Important: If any Injury or 4 □ Donation 5 Other (Specify) F N TO THE STATE OF THE S MARRIOTTSVILLE, MD 12/1/99 CRESTLAWN MAUSOLEUM 22. Name and Address of Fecility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228 Da not exter the mode of dying, such es cardiac or respiretory errest, Part 1. Enter the disease, or complications that caused the de shock, or heart feilure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 1 de disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last and Due to (or as a consequence of): Box 68760, physician Physician/Medical Due to (or es a consequence of): be detached for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 should certificate has 1 Yes 612No 1 ☐ Yes 2 ☐ No Attending Physician: funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 2 PR/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? After 5 Pending investigation 1 Waturel 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide ò Hospital 29e. Certifier 🔁 Carlinying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of couling 29c. License number 29d Date igned (Month, Day, Year) 290 30. Name and andress of person who ed cause of death (ftem 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Monty, Pay, Year)



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DHMH 16 Rev 6/95

State Registrar

J. Jagar

32. Registrar's Signature

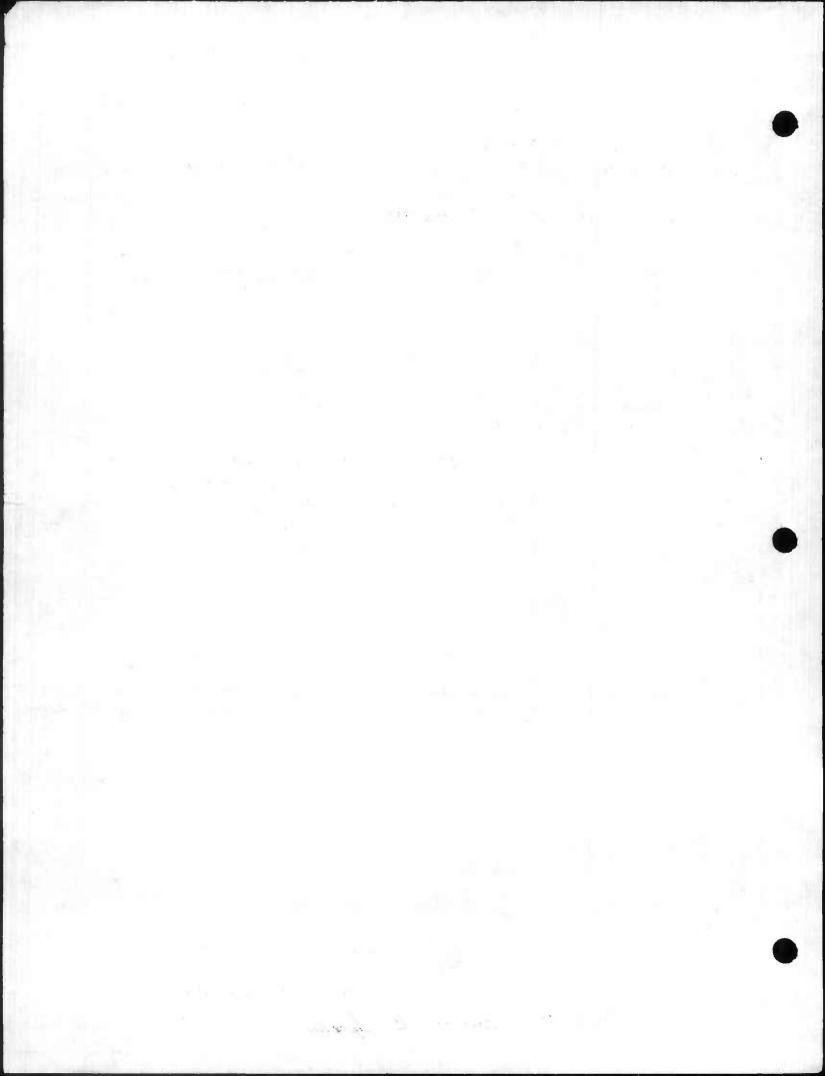
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31. Date filed (Month, Day, Year)

B. Sparket

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month 3. Tima of Daath Day **Physician** Year Peter George 1,1999 Dec 2:30a.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 7121 Eastbrook Avenue Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 10 17 19 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 M 2 F 83 Yrs. 1916 Director 216-01-2361 Greece Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 Yas 2 No Director Md N/A 288-1 Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rems 23s or 7121 Eastbrook Funeral 21224 Avenue USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, apecify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married T∑ Yas 2 No BYas, Giva Yaar or Datas: WW II Baltimore, Maryland 21215-0020 b 1 ☐ Yas 2 ☐ No Specify. Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Elamentery/Secondary (0-12) College (1-4or 5+) Designer/Draftsman Steel 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be it Department of Health and Mental it Important: If Item 27 is marked of any Injury or other traumatic ave Anthony Georgoulos Mary Haritou 19e. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Penelope George/wife 7121 Eastbrook Avenue, Balto, Md 21224 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 Cramation 3 Ramoval from Stata Oaklawn 12/3 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensea 22. Nama and Addrass of Facility Bradley-Ashton-Matthews Funeral Home, Inc recus 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Md 21222 Approximate Interval Between Onset and Death **Physician** tmmediete Causa (Finet disaasa or condition resulting in death) /Medical Blidder Cancer 2 yers Examiner Dua to (or as e consequence of): Examiner the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Lest Dua to (or as a consequence of): P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of) for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributs to the cause of death? or verificata has been signed by director, page 2 should be detact 1 ☐ Yea 2 No 3 Probably 4 Unknown 1SCHEMIC hemT DISENSE Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy COPO this certificata has 2× No 1 🗆 Yas of Vital or Attending Physician: 25. Was casa refarred to medicat axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yas 2 No 27. Menner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending Invastigation death. 1 ☐ Yas 2 ☐ No 2 ☐ Accidant 24 hours after deal Funeral Director: 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Steta) filled in by 4 Homleida Hospital 29a. Certifier Certifying Physician: To tha best of my knowledge, deeth occurred et the tima, data and place, and dua to the cause(s) and mannar as stated. pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the causa(s) and menner stated. To the To the Comple 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 038400 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) SHMFMN FALLS RO , CUTHURULUS , MD , 21093 WILLIAM 10751

DHMH 16 Rev 6/95

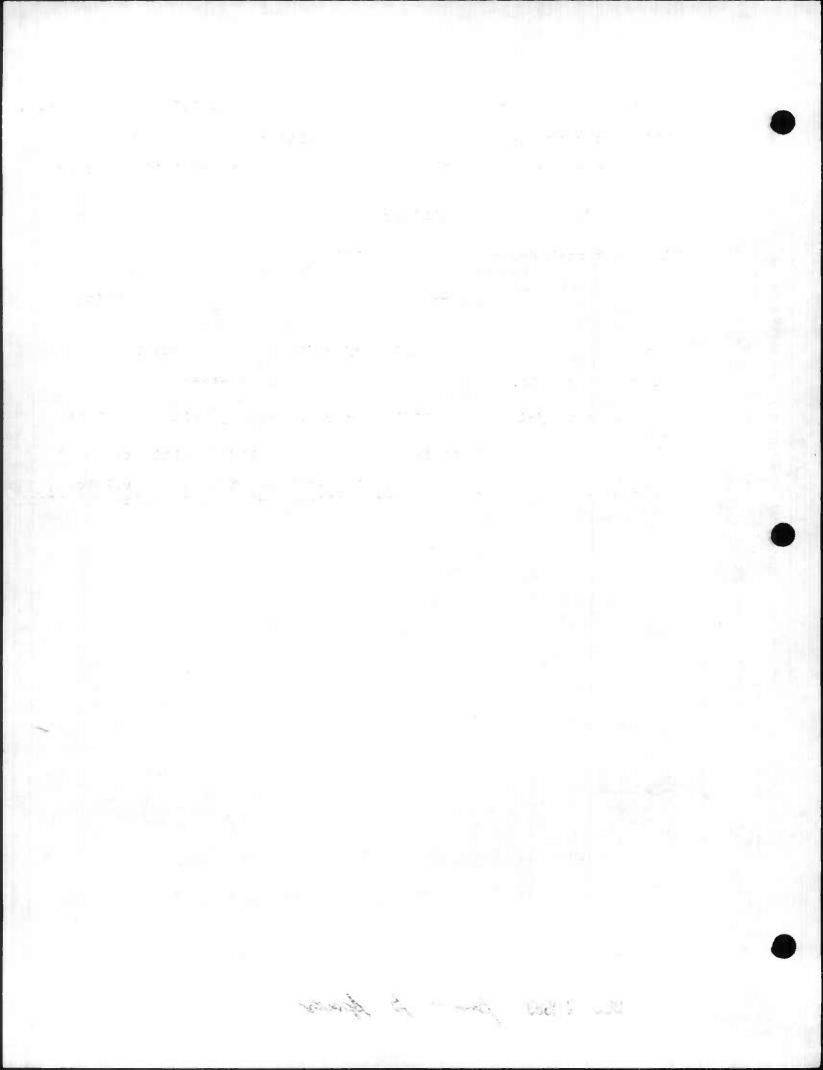
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Registrar

31. Data filed (Month, Day, Year) DEC 3

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32. Registrer's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

						Cer	tificat	e of	Death			Reg. No.			
			1. Decedent's Name (First, Middle,	Last)							2. Dete of Dec	eth		3. Time o	f Death
	Physici		William M.		Haygo	bod					Month Decembe	Dey	Year 1999	9:00	am
8	/Medic		4e Facility Name (Il not institution,			, o a			4b. City, To		ocation of Death		ty of Deeth		anı
-	Examin	er													
_			818 Holly Drive		7. Age (In yrs. i	last hirthday)	If Under		Annap If Under		O Date of Die		Arui		ne Ensaign
	Funeral Director		568-20-4236	1/2 M 2□ F	81	Yrs.	Months	Deys	Hours	Min.	(Month, Da	y, Year)		place (State ontry)	or Foreign
	Director		Usual Residence of Decedent						J		May 7,	1910	Man	ıla	
	Due A se		10a. Stete 10b. County		10c. City	y, Town or Lo	cation							10d. Inside C	Ity Limits
	Aery and	0	MD Anne A	rundel	7	man-1:	_							1) Yes	2 □ No
	the l	Director	10e. Street and Number	runder	All	napoli	10f. Zip	Code				10g. Citizen of	What Car		
	E P E						101. Zip					Tog. CRIZER OF	What Cou	intry r	
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	hours after death with the Meryland lursi', or Heme 23a or 28a-f ahow at Examiner mast be nothled at	Funeral	11. Meritel Status	Armed For	ident Ever in U, rces?	S. 13. V	Vas Deced f Yes, spec	dent of F cify Cub	lispanic Ori an, Mexica	igin? (Sp 1, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bio	ice - Ameri eck, White,	ican tndien, , etc.	
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Maryland 21215-0020	natural',	d by	3 Widowed 4 Divorced	Year or Da	ates:			A	-,,			- Open	A. A411	ILE	
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P	tel Hygi d other event,	Be	17. Father's Name (First, Middle, Li	ist)					18. Mothe	er's Nam	e (First, Middle,	Maiden Sume	me)		
la		0	Claude Haygood						Anni	e La	urie				
an	d 2 should th and Mer 7 la marke traumatic		19a. Informant's Neme/Relationshi	p (Type, Print)		19b. Meilin	g Address	(Street	end Numb	er or Run	al Route Numbe	er, City or Town	n, State, Zi	ip Code)	
	r tre		Mary E. Haygood	(Wife)		818	Holly	, Dr	ive E	ast,	Annapo	lis, MI	214	01	
ē,	E P E E	Ì	20a. Method of Disposition		20b. P	lace of Dispo	sition (Ner	ne of			Date	20c. Location	- City or T	own, Stete	
2	BO THE TA		1XXBuriat 2 ☐ Cremetion 3		State	emetery, cren emont			-	ong	12/03	Davids	convi	llo M	D
Baitimore,	permit. Pages Department of Important: If its eny injury or of		4 ☐ Donation 5 ☐ Other (Special Superior of Funeral Service Li		Пак						12/03	Davius	SOIIVI.	rre, M	
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	Physician				^	Δ.			_					Onset and	
	_/Medical		Immediate Cause (Finat disease or condition	*	ESD	RA	10	KY		AI	LUR	E		3 1	105
	Examiner		resulting in death)	8.	Due to (or	r as a conseq	uence of:			1,,	LUR	^			10
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ó	e car	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C											
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Division	or Attending later death. Director: After lin by the fune	€	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place of injury - At home, term, street, factory, office						28f. Location (Street end Number or Rural Route Number, City or Town, State)					
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	To the Hospital or Attending Phy within 24 hours after death. To the Funseal Director: After this completely filled in by the funeral	edical	(Check only 2 Medical Ex	uminer: Op the ba	isis of examinat ner stated.	ion and/or inv	estigation,	in my o	pinion, des	ith occuri	red at the time,	dete end place	, and due	to the cause(8)
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM #18 PER INF G829 3/11/04 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Day **Physician** laine November 26 199 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 11-01-40 Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2□F Months NC 218-36-9972 59 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours efter death with the Manyler it hend Mental hygiene.
7 le marked other then "natural", or Kerna 23a or 28a-f show treumrate event, pre Media Estering the motified as MD NA Baltimore 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Evesham Avenue 21212 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry entary/Secondary (0-12) College (1-4or 5+) NA Emergency Medical Tech. Company 11th Grade Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelith and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic event pages. 80 Kelly CALLIE Bell Norris Grover 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2573 Mindi Drive Manchester, Maryland Futrell Robin 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 12-02-99 Randallstown, MD Kings Mem. Pk. Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funeral Service Licenses Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue M Part1. Enter the disease, or complicate shock, or heart failure. List only one of enter the mode of dying, such es cardiac or respiretory arrest, Approximate Intervet Between Onset and Deeth **Physician** /Medical Immediate Cause (Final STRUCTIVE disease or condition resulting in death) DNIL Examiner Due to (or as e consequence of) 13BASG Examiner sician end buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the burie ULMONARY Box 68760. Physician/Medical Due to (or as e consequence of): 180 08U been signed by the ettending should be deteched for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 2 24b. Were eutopsy findings aveilable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 PN6 certificate Division of Vitai or Attending Physicien: funeral director, 8 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mangel of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury al Work? After Netural 5 Pending To the Hospital or Attendit within 24 hours after death. To the Funerel Director: Al 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated. 29b, Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 199 sucen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7220 AKITANI, SNEEM 31. Date filed (Month Day, Year) 32. Regist er's Signeture State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#3 perPhyG778 12/22/99 EW 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth **Physician** Marris Month PM Edgar November 30,1999 9:00am /Medical 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 461 Kyle Road Crownsville Anne Arundel 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 6. Sex 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** Deys 1⊠M 2□F Yrs. Director 226-38-4468 68 Dec.6,1930 Virginia Usuel Residence of Decedent death with the Menyland 10e. Steta 10b. County 10c. City, Town or Location 10d. tnslde City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Modical Example must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 461 Kyle Road 21032 USA Funeral 11. Marital Status 12. Wes Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 18b. Kind of Business/Industry de complated) Elamantery/Secondary (0-12) College (1-4or 5+) Lead Man National Plastics 17. Fether's Neme (First, Middle, Last) 18. Mother'e Neme (First, Middla, Meldan Sumama) Thomas Harris Grace Rouse 19e. tnformant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Betty Lou Harris - Wife 461 Kyle Road, Crownsville, MD 20b. Plece of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removel from Stata Metro Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 12/2 Baltimore, MD 22. Neme end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, list only one cause on each line. Approximate Interval Between Onset and Death **Physician** Presmonia /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner 15 months Cancer buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events rasuiting in deeth) Lest Due to (or es e consequence of). physician s the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other etgniftcent condittona contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? the been signed by should be detac 1 Nee 2 No 3 Probably 4 Unknown Emphysema by 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? 24a. Wes en eutopey performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Wes case referred to medical Be 26. Pleca of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No 28a. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. tnjury et Work? 28d. Describe how Injury occurred Certification: 5 Pending invastigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) In by 4 - Homicide 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) and menner steted. 29a, Certifier Medical (Check only one)

State Registrar

32. Registrer's Signeture

Werner

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

900

29b. Signatura and title of certifier

Clume

Bestgate Road, Annapolis, MD 21401

29c. License number

D52830

29d. Date signed (Month, Day, Year)

December 1,1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** Helen Harrel NOV 30 1999 10:36 PM /Medical 4e Fscility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel # Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2□XF Months 220-12-8879 Director 1926 Maryland Usual Residence of Decedent with the Meryland 10a. Sfete 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Madical Examiner must be notified at once. 10b. County tOd. Inside City Limits MD N/A Baltimore 1X Yes 2 No Directo 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of Whet Country? 21218 3619 Elcader Road USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Merifel Status 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White b 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leopold Flatcher Antonia Yoppi 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 758 S. Mesa Rd., Millersville, MD 21108 Charlotte Campitelli/niece 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 12/02/99 Baltimore, MD 4 Donetion 5 Other (Specify) Metro Crematory, Inc. ²² Neme end Address of Facility
Cremation Society of Maryland, Inc. 21. Signeture of Puperal Service Licenses 299 Frederick Rd. Baltimore, MD 21228 Gregorchik Edward A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betwo Onset end De **Physician** DISEASE PARKINSUNS fmmediete Ceuse (Finel diseese or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown of Vitai Records, by Be Completed 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Was en eutopsy performed? 2 M No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient edical Certification: To 3 DOA After this 27. Menner of Death 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation death. 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - Af home, ferm, streef, factory, office building, etc. (Specify) To the Hospital or A within 24 hours efter To the Funeral Direc completely filled in by efter 4 ☐ HomicIde 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

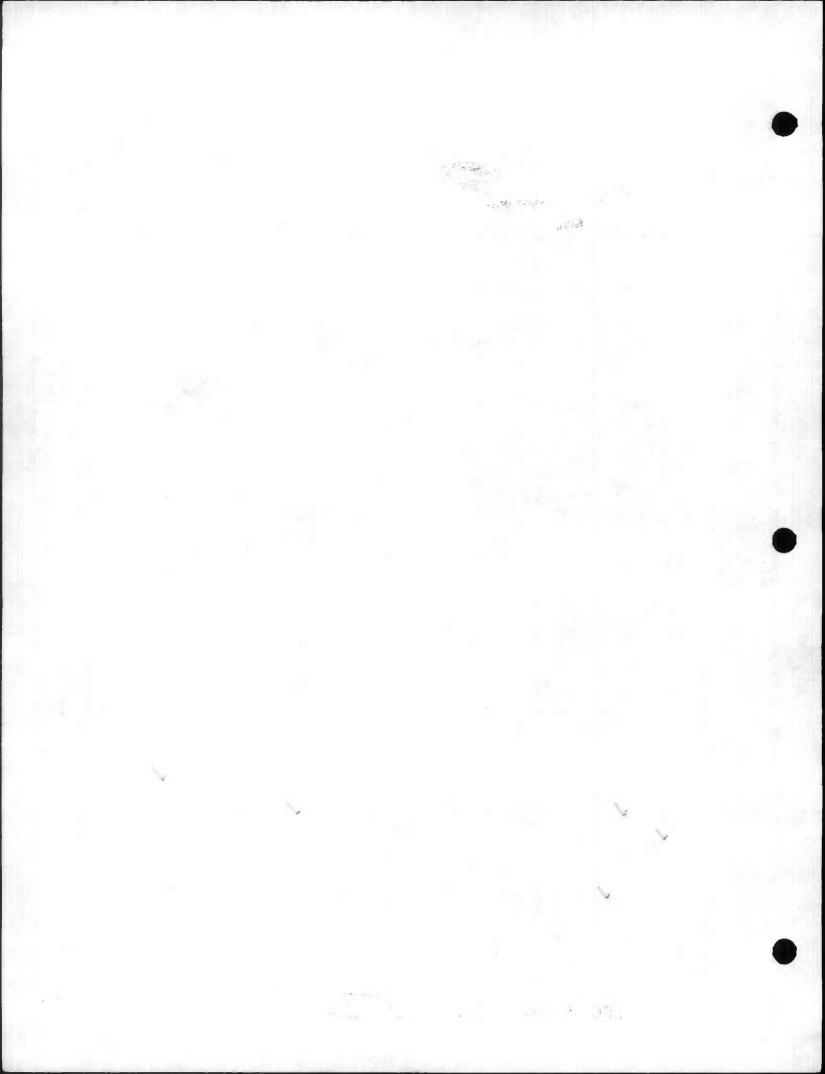
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier (Check only one) 29b. Signeture and title of contilent 29d. Date signed (Month, Day, Year) daddress of person who completed cause of death (Item 23e) (Type, Print) Year) ₫

Registrar **DHMH 16 Rav 6/95**

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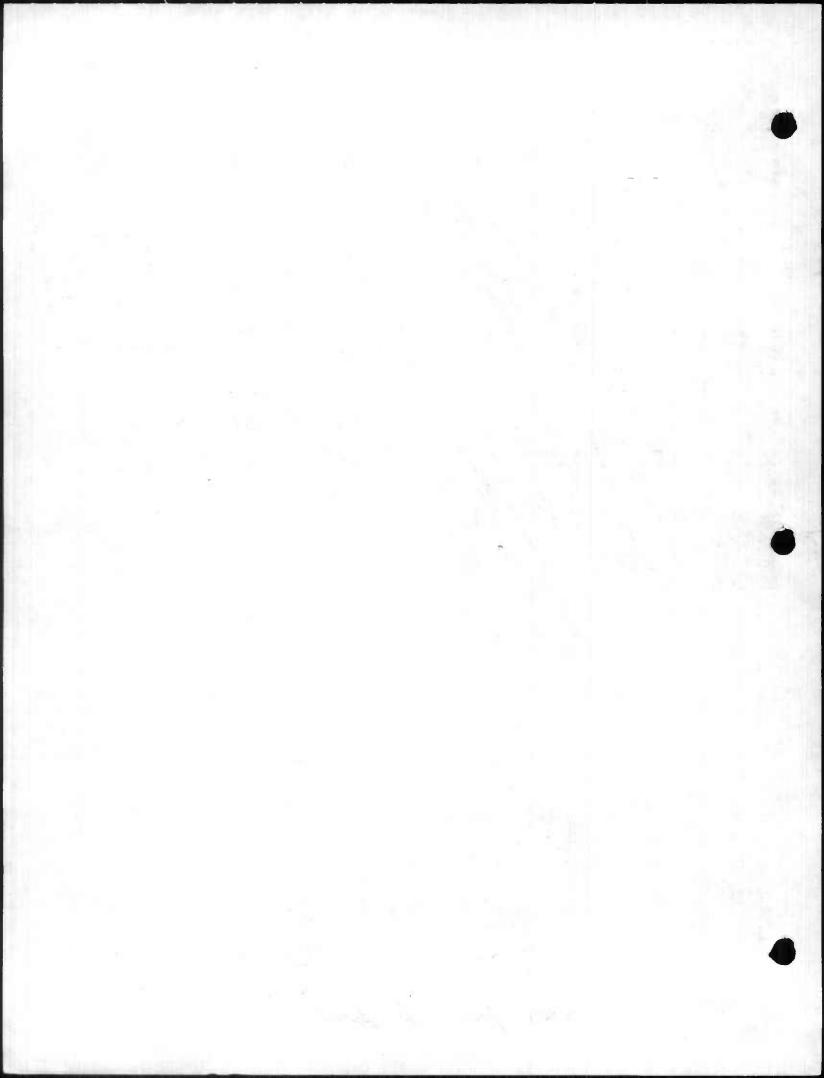
111 Penn Street, Baltimore, Maryland 21201

Fowler

32. Registrar's Signeture

Javid

31. Date filed (Month, Day, Year) DEC 0 3 1999



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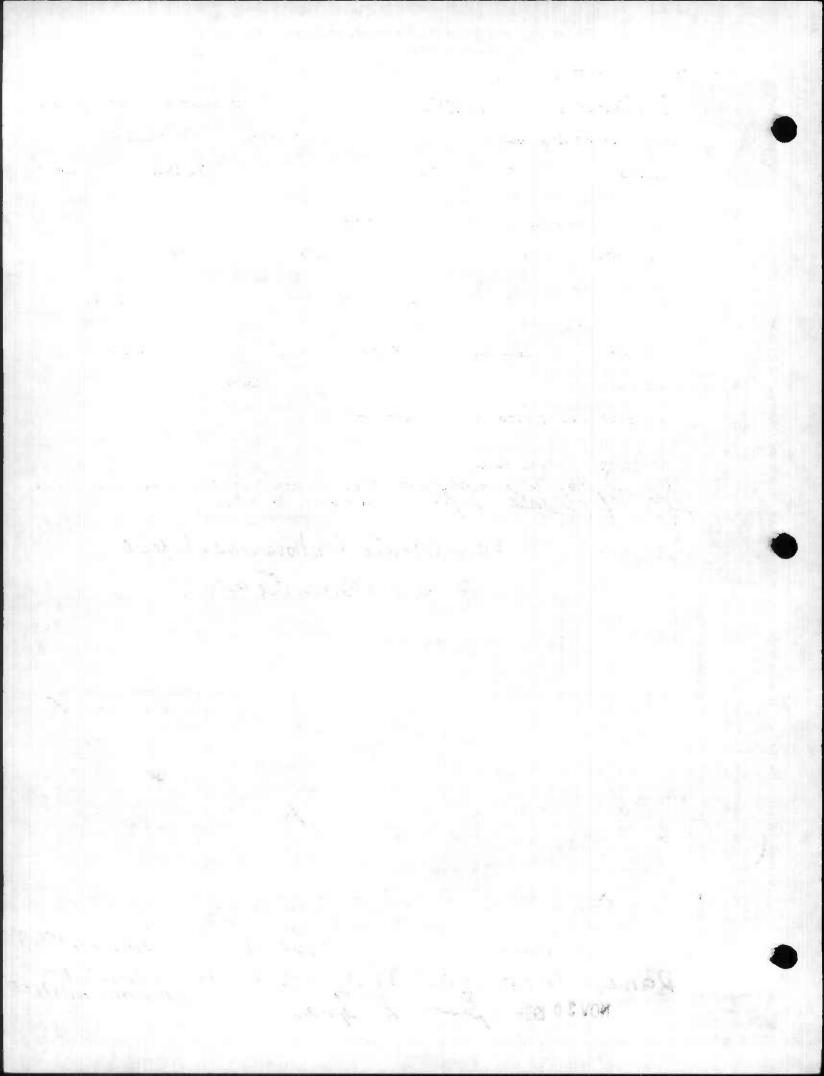
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#24a perPhyG778 12/03/99 EW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth November I **Physician** a (herine 9:20 PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Baltimore Harborside Nursing Home Baltimore If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) May 17, 1909 Birthplece (State or Foreign Country)
 unknown 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□M 2₩F 90 Yrs. unknown Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show trsumstic sysut, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21213 USA 4700 Harford Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 N Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7. al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) inknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 2 should be fill and Mental H Be unknown unknown 19e. fnforment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If from 27 is n any injury or other treun Rita Stevonavich/daughter unknown 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 □ Donellon 5 ♥ Other (Specify) An state Signature of Funeral Service Lipegae 22. Name and Address of Fecility
State Anatomy Board 655 W. Baltimore Street Wade, Director 12-499 Baltimore, MD 21201 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Altero Sclerotic Cardiovascular Disease /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner attending physician and for use es the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? P.O. Pert ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Were autopsy findings evailable prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? s certificate has b 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Physicien: unarel director, 25. Wes case referred to medical exeminer? 26. Placa of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending 1 Naturef 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ HomicIde o Ho Hospital of 24 hours a
 Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) vithin 2 To the 29d. Dete signed (Month, Day, Year) No venber 23 1999 29b. Signeture end title of certifier 29c. License number 730641 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

Rames & Sabana (La' Suite 308 821N Extra Structure)

Rames & Sabana (La' Suite 308 821N Samme MD2120)

State Registrar



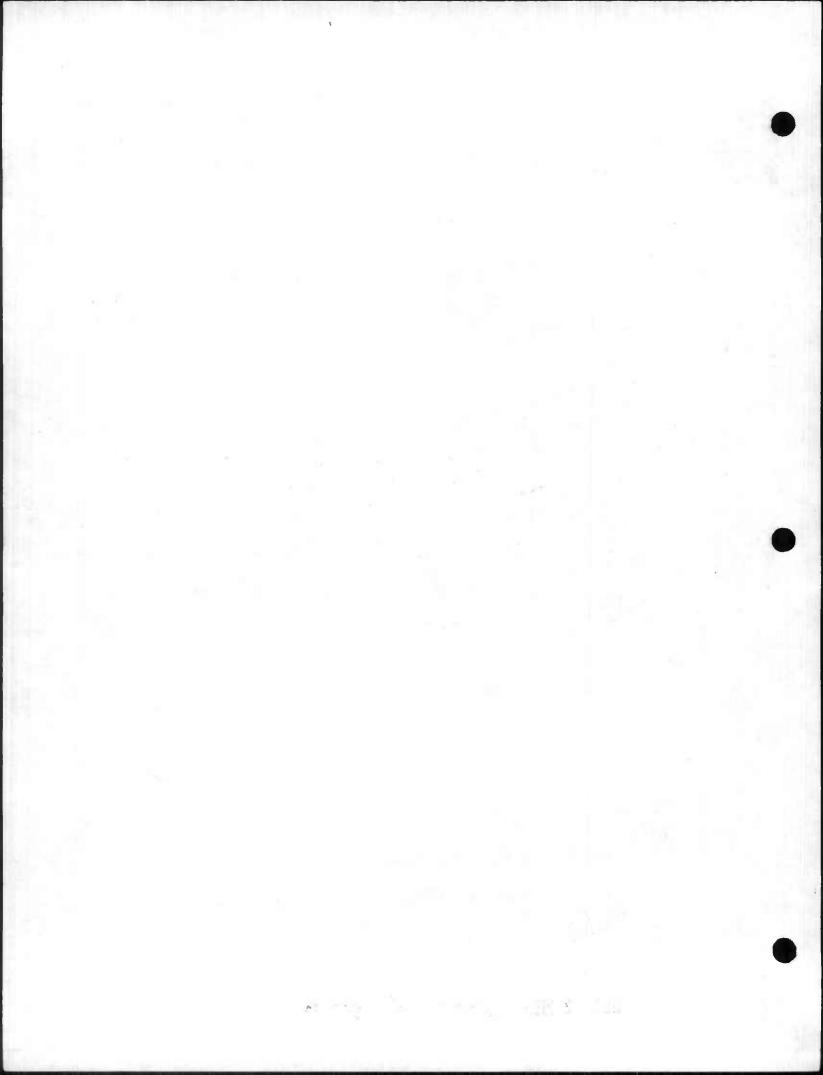
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William Physician Month SOK ai December 1, 1999 2:55 p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Yeer | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex XXM 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 83 Yrs 064-09-4127 Nov. 21, 1916 York Director New Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Montgomery Silver Spring 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1318 Mimosa Lane 20904 USA Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 abould be flied within 72 hours after next of Health and Mental Hygiene. 1 XYes 2 No If Yes, Give 1 Never Merried 2 Married b altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3€ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Department of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o August Isokait Marie Ammon 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other tra-William A. Isokait/Son 2902 Jennings Road, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park 12/7/99 Rockville, Maryland 22. Name and Address of Facility 21. Signature of Funerel Service Licenses Fleck Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

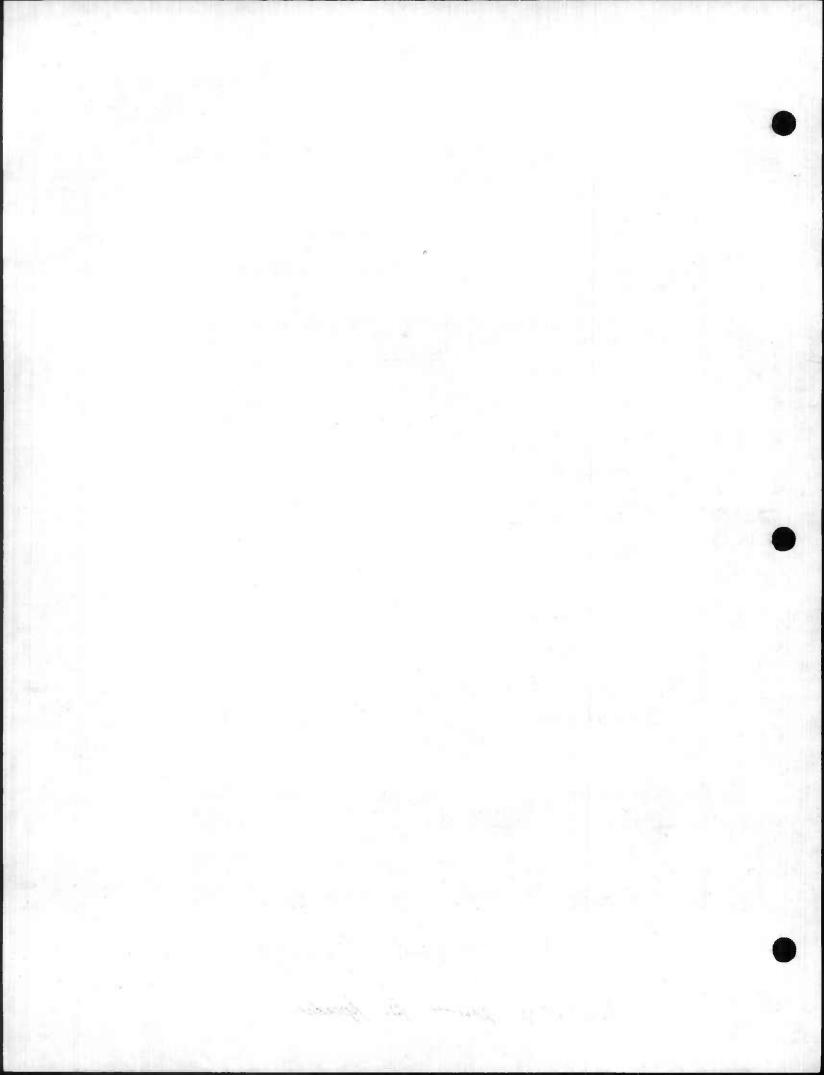
Approximete Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physiclan/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760. COLOVEUR Due to (or as e consequence of been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29b. Signetur 29d. Date signed (Month, Day, Year) Michael Fraymo 00053271 the completed cause of deeth (Item 23a) (Type, Print) 5: (Ver Spring, MD 20906)

201-460-8282 32. Registrar's Signature State Registrar

DHMH 16 Rsv 6/95



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Registrar

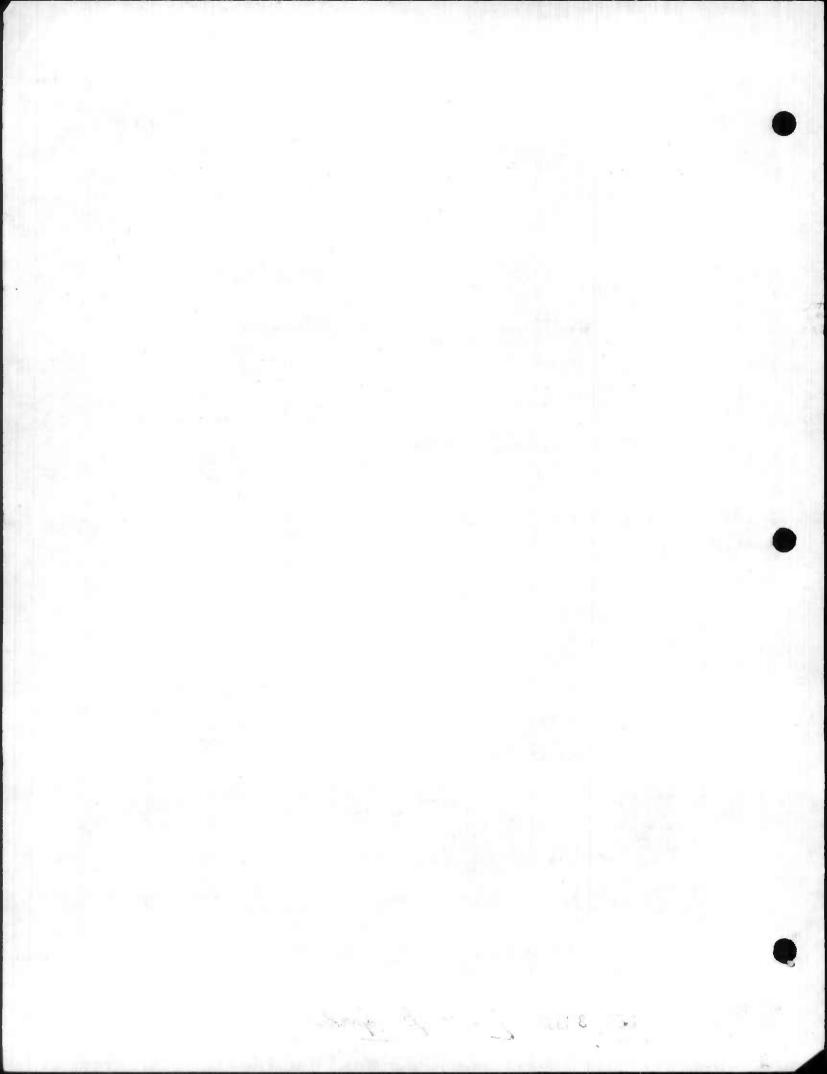
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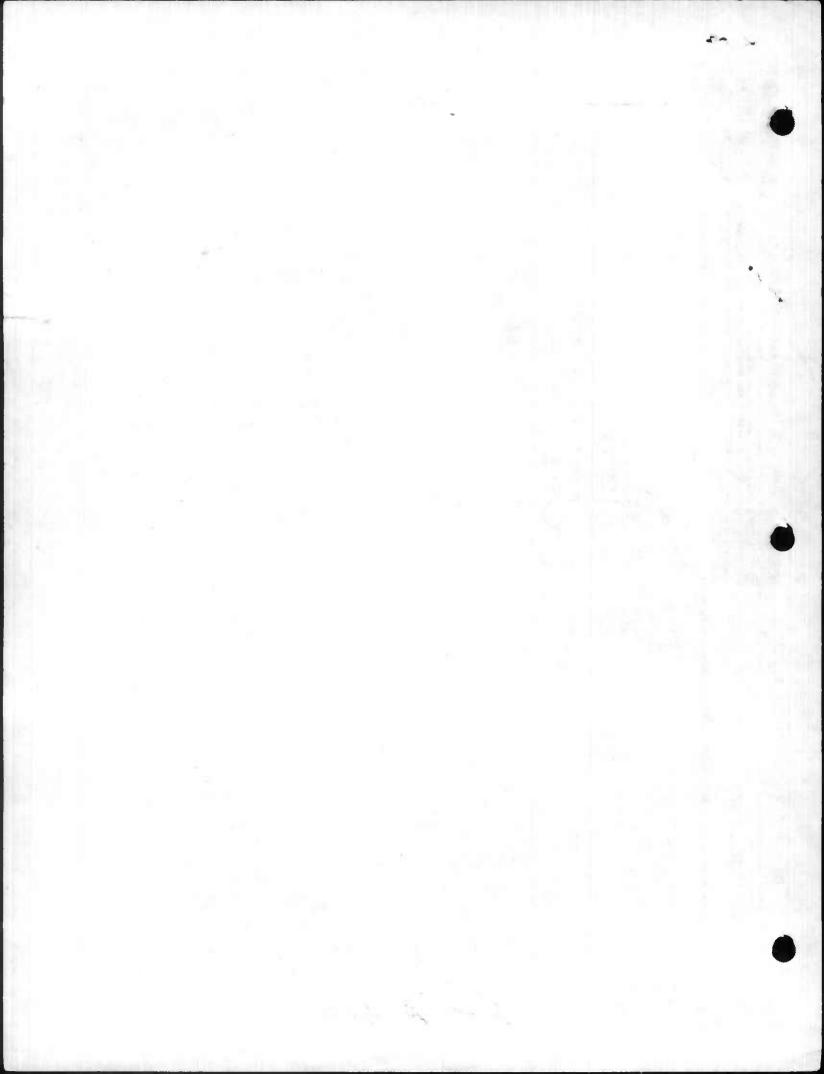
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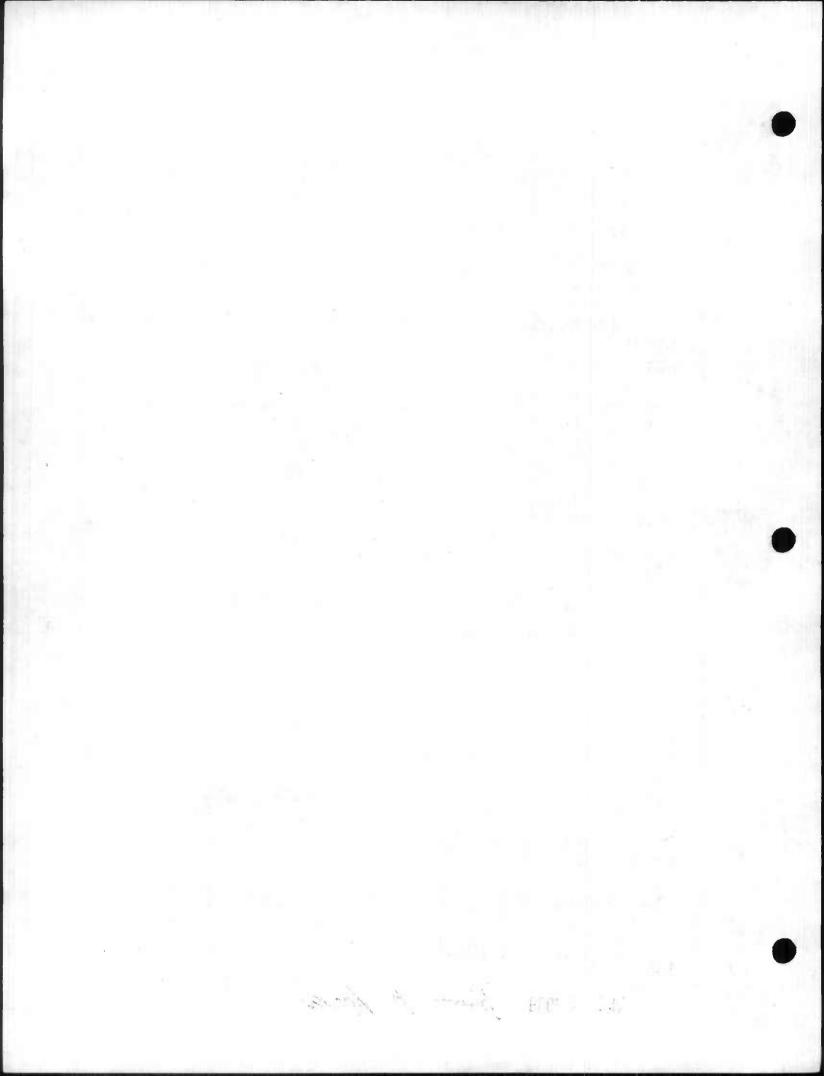


MARCUS JCASSO 99-7060-510	1 23a,27,28a N d,e,f,per	b.CPlage	2/18/00 yg Type or Prin State of Ma	t in Riac	k Indelible Inl	Health and	All Coples Mental Hy	Are Legi giene	ble.		
AMEND:	ITEMS#		" KEON MA	DOUG LI	Certificate of LLIAMS-JOH		2. Date of De	Reg. No.	9 378123		
Physician /Medical	1001100000	cos	" REON MA	NSON	Month NOVEME	Dey	Year 1999 1933 PM				
Examiner		f not institution, give EMORIAL H	ostreet and number) OSPITAL			4b. City, Town, or BALTIMOR		,	of Death NA		
Funeral Director	5. Social Security N	3831	7. Age	(In yrs. last bi	rthday) If Under 1 Yea Months Days			rth ay, Year) -98	Birthplace (State or Foreign Country) M D		
with the Maryland a or 28e4 show the notified at Director	Usuat Residence of Decedent 10a. Stete 10b. County MD NA			10c. City, Tow Balt	m or Location	10 00 00 00 00 00		10d. fnside City Limits X Ži Yes 2 ☐ No			
h with the Mar 23e or 28e-f s at be notified al Director	10e. Street and Nur 1114 M		er Street		10f. Zip Code 212			What Country?			
5-0020 72 hours after the with the Maryle natural, or flems 23s or 28s f sho steal Examiner must be notified at sted by Funeral Director	11. Maritel Status 12. Was Decedent Armed Forces 1 Never Married 2 Married 1 Yes 2 🔀				13. Wes Decedent of If Yes, specify Cu		Specify Yes or No to Rican, etc.)		e - American Indien, sk, White, etc. * Black		
Maryland 21215-0020 of 2 should be find within 72 hours at lifth and Mental Hygiene. 27 Is merched other than "natural", or 1 traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or Child Child			N)	Decedent's Usual Occi (Give kind of work don tife. DO NOT use retir hild	upation e during most of wo red)	rking	16b. Kind of Br	d		
	17. Fether's Name	(First, Middle, Last) Johr	nson			18. Mother's Nar Diane	me (First, Middle, Maiden Sumame) Johnson				
othe othe	Ellen 20e. Method of Disp	Cremetion 3 🗆	Removal from State	20b. Piece of cemete	D. Mailing Address (Street 14 Avedon 1 Disposition (Name of ny, cremetory or other plants)	Court 3	Joppa, Dete	State, Zip Code) nd 21085 City or Town, State ndalk / MD			
Baltimo permit. Page Department of Important: If any Injury or once.	21. Signeture of Fu	5 Other (Specify nerel Service Licen		Voshell Mem. Gardens 12-03-99 Dundalk 22. Name end Address of Facility Baltimore, Maryland WM.C. March FH 1101 E. North Aven							
Physician /Medical Examiner	Immediate Cause (disease or condition resulting in deeth)	fitaliure. List only c	e cause on each life DEHMORAT	TION	not enter the mode of dy	ying, such es cardia	c or respiretory e	errest,	Approximate Intervel Between Onset and Death		
I Records, P.O. Box 68760, The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be deteched for use as the burial-transit completed by Physician/Medical Examiner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or that initiated events resulting in deeth) I	rediete rlying injury	c	Due to (or es a							
ds, P.O. B iras that the deat signed by the art d be detached for d by Physicia	Part II. Other atgniff	cant conditions co	ntributing to death but	23b. Did tobacco use contribute to the cause of de							
aw requir							24a. Wes en autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?		
f Vital Royston: The ingression of director, page	25. Was casa referr	-					eth (Check only	one)			
Division of Vita To the Heaptal or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. Medical Certification: To Be (27. Menner of Death 1 Netural 2 Accident	5 Panding investigation	28e. Date of Injury for Month, Day 11/2	28e. Date of Injury 28b. Time of P 28c. tnjury et Work? 11/25/99 CUTK! M 28c. tnjury et Work?				ing Home 5 - Residence 6 - Other (Specify) 28d. Describe how injury occurred SUDJECT Was dehydrated			
Division of within 24 hours after death of the thorsel Director. After the completely filled in by the funeral Medical Certification:	3 ☐ Suicide 4 ☐ Homicide 29a, Certifier	6 Decould not be determined	found: re	sidence	arm, street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1114 Montpelier St. Baltimore, Mil 1114 Montpelier St. e, end due to the cause(s) and manner as stated.				
he Hospin 24 hound he Funer pletely fill		2X Medical Exam	ner: On the basis of e and manner state	examination an	d/or investigation, in my	opinion, deeth occu	urred at the time,	, date and place,	and due to the cause(s)		
To the Within To the Comp	296. Signature and	your h	ne Yhell		√n	nse number CME			d (Month, Day, Year) R 25, 1999		
	MARLA	and 1	ompleted cause of deal		(Type, Print) In Street, I	Baltimore	, Maryla	and 2120	1		
State Registrar	31. Dete tiled (Mont	C 0 3 199	32. Begistrer		9. Spark						



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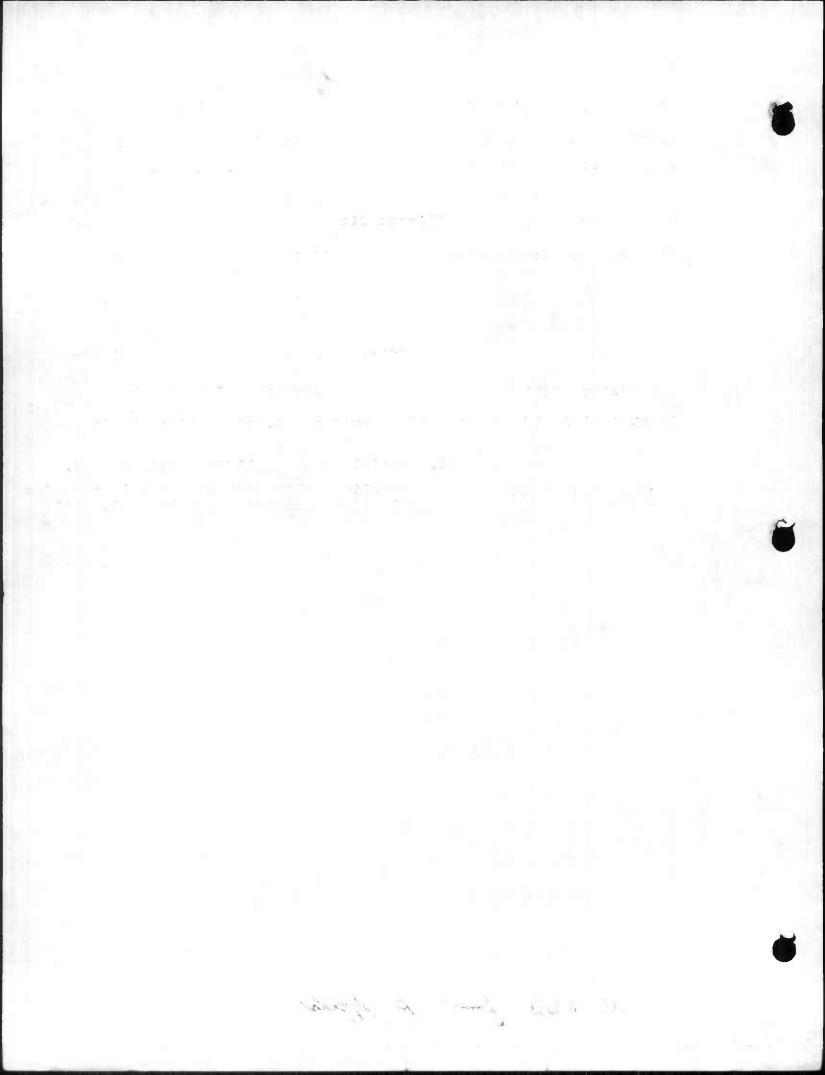
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		. Decedent's Neme (First, Middle, I	of De	alli	2. Data of D) ,	3. Time of Death					
Physician		Joan R.				Month Nov	Dey	Year	6 45				
/Medica		e Facility Nema (If not institution, g	Nov 24,1999 4b. City, Town, or Location of Death 4c. County of Death					6:45 am					
Examine	18	Howard County		.,									
Funeral				Age (In yrs. I	last birthday)	If Under 1 Y	ear If L	Inder 24 Hrs.	8 Date of Bi	rth	ward 9. Birtho	lece (State or Foreign	
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Ma-fa	oto _	Md Howard	3	El	licot	t Cit	У					1 ☐ Yas 2 ☐ No	
1 2 2 E	2 1	0e. Street and Number				10f. Zip Co	de			10g. Citizen of	Whet Coun	itry?	
tel Hygiene. Itel Hygiene. Itel Hygiene. John Harn "natural", or Herra 23a or 28a-f ahow event, the Medical Emerical must be notified at event, the Medical Emerical must be notified at event, the Medical Emerical Func	<u>a</u>	3317 Coventry Court Drive					2104	2		Ţ	JSA		
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and 2 and 2 a saith ar n 27 is		Albert Jagiels		and						Ellicot			
fe, IV f Health tham 27 other tr	- 1-	Oa. Method of Disposition		20b. P	tace of Dispos	ition (Name o	of	CL.D	Date	20c. Location			
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Baltim permit. Pag Department Important: I any Injury o		21. Signature of Funerel Service Lic	ensee	7	22.	Name and A	ddress of	Fecility					
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4		23a. Part1. Enter the disease, or co	mplications that caus	ed the death	n. Do not ente	the mode of	dying, su	ch as cardiac	or raspiratory	Balto,	Md.	Approximate	
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/Medical		mmediete Cause (Finat disease or condition	(ama)	MATIO	INS ED	aten	10	mu 14	ok m	yelomu	2 1	5 months	
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be executed sician and burial-transit	E	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or es a consequence of): Due to (or es a consequence of):											
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the d	P P	ert II. Other significant conditions	contributing to death	but not resu	ilting in the und	derlying caus	e given in	Part I.	23b. Did	tobacco use c	ontribute to	the cause of death?	
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	5 2	5. Was case referred to medical examiner? 1 Yes 2 No	Hospitel:	tions of	EDIO	-C-00:	Other		th (Check only		h 10		
clan: clan: settifica ector,		1 Yes 2 No	1 Joinpa	iurv	28b. Time of	3□ DOA 28c.	4	☐ Nursing H		how injury occu		y)	
hysiolen: his certifical director,	2	7. Manner of Death		(Month, Day Year)			Injury at Work? 1 ☐ Yas	2 No	200. Describe now injury occurred				
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State of Maryland / Department of Health and Mental Hygiene

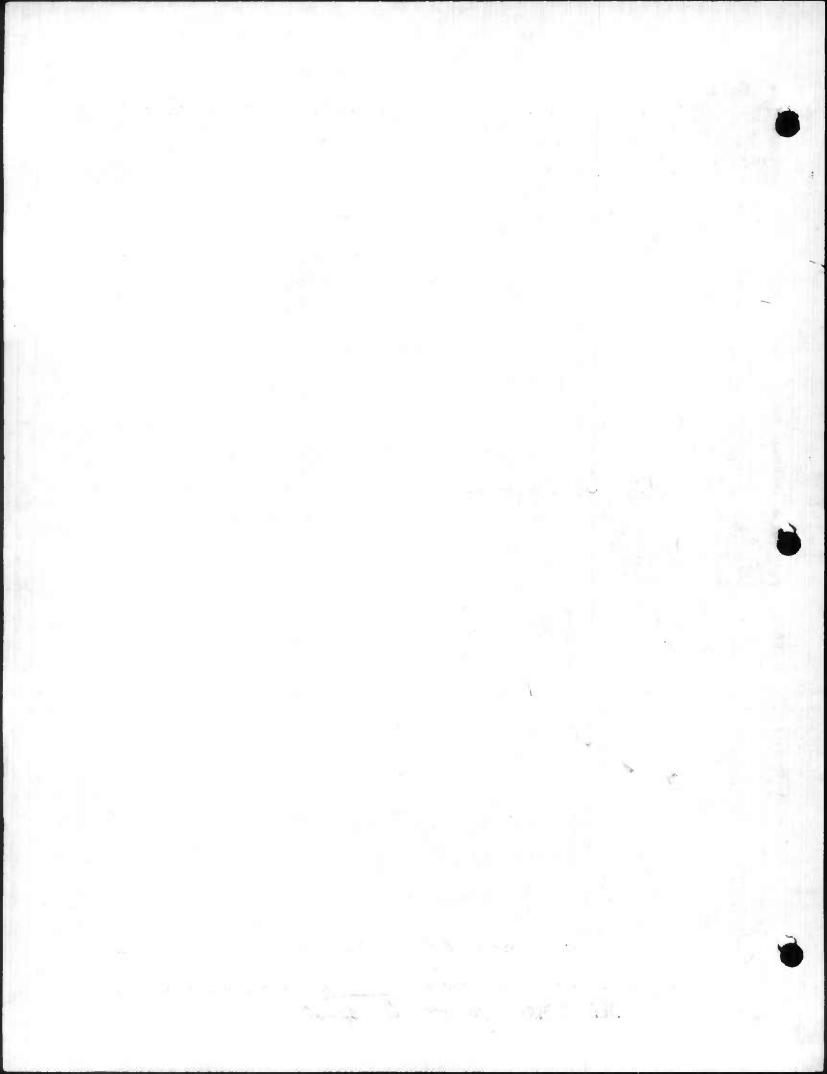
Certificate of Death Reg. No. 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** WILLIAM GRANT KREUZBURG NOVEMBER 29, 1999 6:00 PM /Medical 4e. Fecitity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 402 Domer Avenue Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Deys **X** M 2□ F Yrs Director JAN 6, 1942 212-42-0154 Maryland Usuel Restdenca of Deceden Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director MD Takoma Park 1 ☐ Yes 2 No Montgomery the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 items 23a 20912 Funeral 402 Domer Avenue USA 12. Was Decedent Ever In U.S. Armed Forces? 1960/ I Wyes 2 No 1963 If tes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 No Specify by Specify: White 3 ☐ Widowed 4 ☐ Divorcad "natural', Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Commercial nd Mental Hygiene. merked other than College (1-4or 5+) Elementery/Secondery (0-12) Journeyman Plumber Construction 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be file Deportment of Heelth and Mental Hy Important; if Item 27 is marked other any linjury or other traumatic event ARRs. 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Harvey Wilson Kreuzburg Betty Weigle 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Françoise B. Grecourt/wife 402 Domer Ave., Takoma Park, MD 20912 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 X Cremetlon 3 ☐ Removet from State Metro Crematory, Inc. 11/30/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) ²² Name end Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 21. Signature of Euneral Service Licenses Thomas Gregor 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** tmmediete Ceuse (Final diseese or condition resulting tn death) /Medical ADENOCARCINOMA UNKNOWN PRIMARY Examiner Due to (or es a consequence of): Examiner The lew requiras that the death certificate be executed physician and s the burial-transil Sequentially tist conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or trijury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760, Physician/Medicai Due to (or es e consequenca of): USB BS Por Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown HODGKIN'S DISEASE Records, by page 2 should be 24b. Were autopsy findings evellable prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? certificata 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: in by the funeral director. Be 25. Wes case referred to medicat 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Restdence 6 Other (Specify) 2 this 27. Manner of Death 1 Neturel Dete of tnjury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred After ! 28c. Injury et Work? or Attending 5 Pending Investigation 24 hours efter death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homictde Hospital Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end manner steted. completaly (Check only one) To the 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) MD 25784 NOVEMBER 30, 1999 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) STEVEN KRASNOW, M.D. VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422

32. Registrar's Signeture

Registrar **DHMH 16 Rev 6/95**

State



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month DEC 01, Dey 1999 Catherine Krepps 3:40 AM 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Future Care Nursing Home Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) JAN 1, 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) Days 1□M 2₽F Months 238-12-9201 84 North Carolina **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 Whit Ridge Avenue 21218 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B.M. Fleming Fallie Trice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Whit Ridge Ave., Baltimore, MD 212 ace of Disposition (Name of Date 20c. Location - City or Town, State Celestine Williams/Niece MD 21218 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Metro Crematory, Inc. 12/2/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation Society of Maryland, Inc. Edward A. Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Months disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Alzhans diverse 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of

Examiner attending physician and for use as the burlal-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760. Physician/Medical Records, þ Completed Division of Vital Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

than "natural", or thems 23a or 28a-f

permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygens, introduction: if Item 27 is marked other than "natural; or Item any Injury or other traumatic event, the Medical Federal Contract.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

the Maryland

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 28a. Date of trijury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

29b. Signature and title of certifier 29c. License number D175

29d. Date signed (Month, Dey, Year)

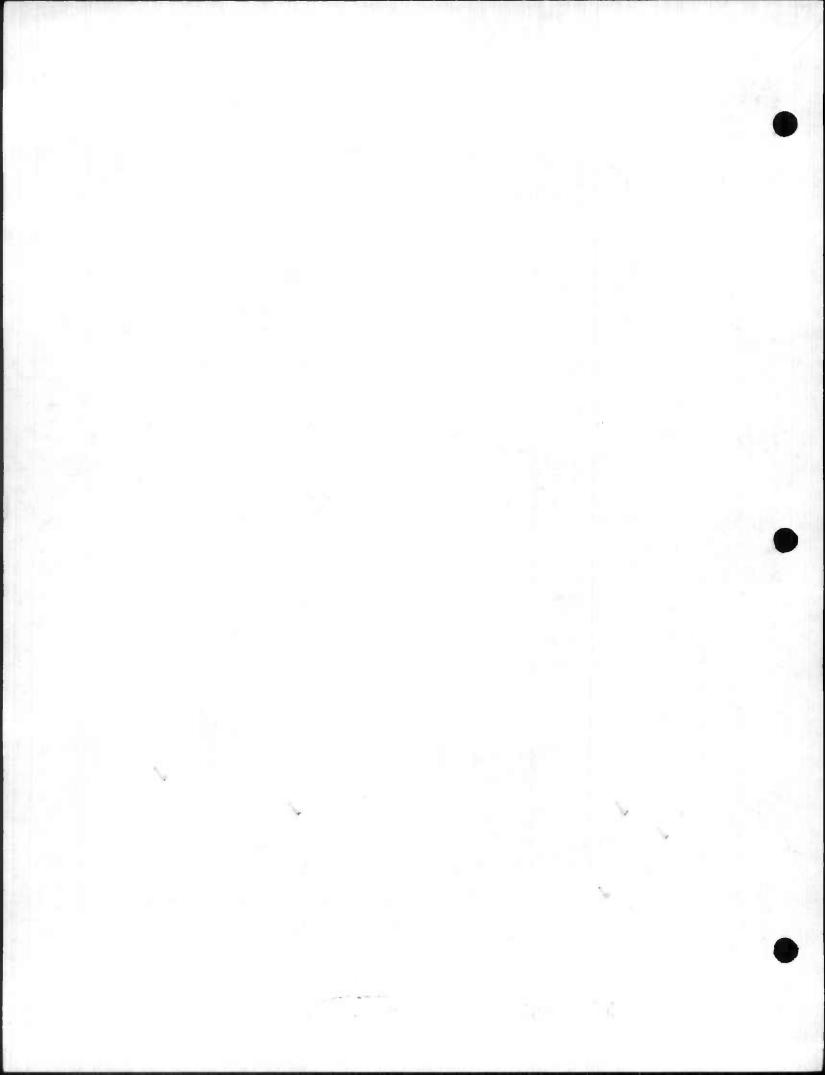
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 W. MOUNT R DARSKANS. SALYA

State Registrar

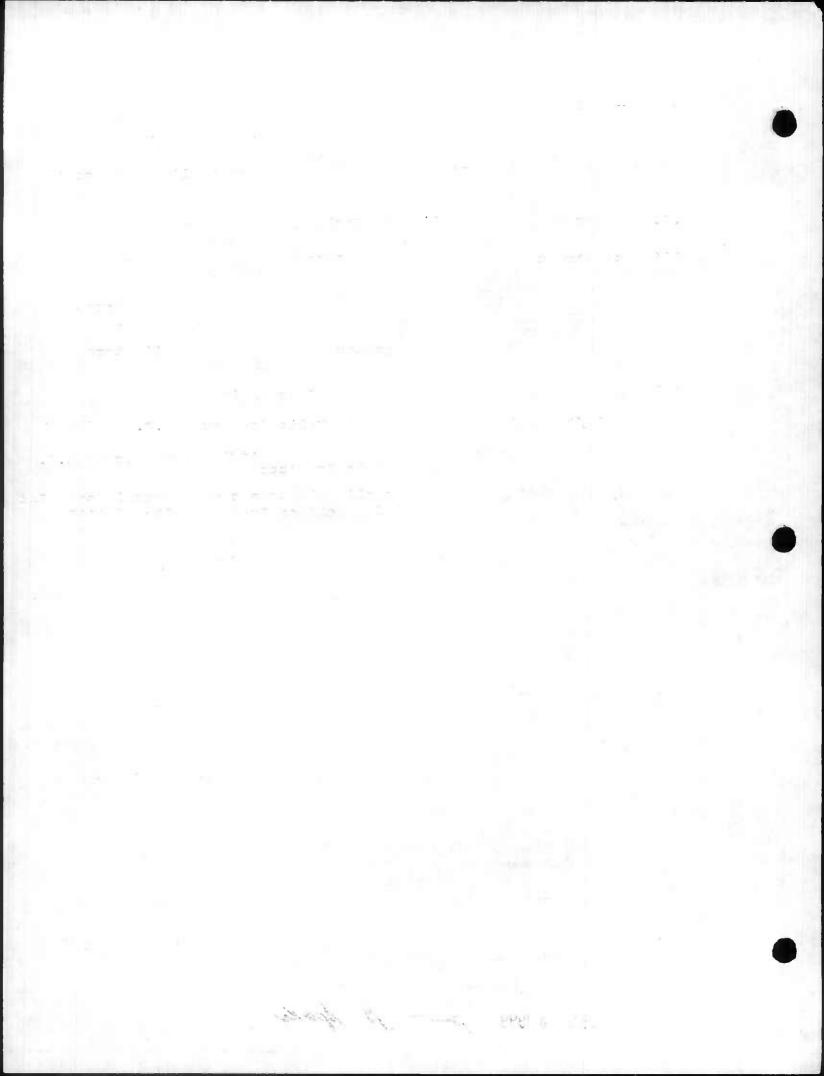
Medical

31. Date filed (Month, Day Year) 1999

32. Registrar's Signature



DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q AMEND ITEMS: #23 PART I, 27, 28A-F Berliffeld of beath 2-3-99 WR. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Mary C. Lancaster November 28 1999 1816 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore None If Undar 1 Yaar If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Hours Min 1□M 2\ F 473-05-4775 88 Nov 24, 1911 New York Usual Rasidance of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 1 Yas 2 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4078 Fragile Sale Way 21042 United States 12. Was Dacedent Evar in U,S. Armed Forcas? Race - Amaricen Indian Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 € No Specify: Specify: 3 DWidowad 4 □ Divorcad White 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Manager Federal Government 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) Andrew Farkas Susan Borbely 19e, Informant's Nama/Reletionship (Type, Print) 19b. Mailing Address (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Richard A. Lancaster/Son 3614 Morning View Court Ellicott City, MD 21042 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ⊠ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 12-1-99 Wheaton, MD 21. Signatura of Funaral Sarvice Licanses 22. Nama and Addrass of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset end Death Immediate Cause (Finel disaasa or condition rasulting In daath) Sepsis One Week Due to (or es a consequence of) Renal Failure 5 days Dua to (or as a consequence of): THERMAL BURNS Dua to (or as a consequence of): Old tobacco use contribute to the cause of death?

Physician /Medical Examiner

physician and the burial-transit

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page 2

funaral director,

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24 hours a Hospital

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P.O. Box 68760,

Division of Vital Records,

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To the within 2 To the I Examiner

Physician/Medical

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Certification:

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ir than "natural", or items 23s or 28s-f show the Medical Example: result be notified at

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Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cousa (Diseasa or injury thet initieted avents rasulting In death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying couse given in Part II.

24a. Was an autopsy performad?

Yes 2 No 3 Probably 4 Unknown

24b. Wara autopsy findings availabla prior to complation of causa of daath?

a No

26. Placa of Death (Check only ona)

1 ☐ Yes 2 ☐ No

25. Was cesa rafarrad to medical axaminer? 1 Yas 2K No

27. Mannar of Death

1X Natural

2 Accidant

4 D Homicida

3 Suicida

Hospital:

5 Panding Invastigation

6 Could not be datarminad

1 Monpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) Wyenser 2,1999

28b Time of 1230PM

Home

28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28c. Injury at Work? 1 Yas 2 No

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 28d. Dascribe how Injury occurred from stove Flame BURN

281. Location (Streat and Number or Rural Route Number, City or Town, State) 4078 Fragile Sale Way

29a. Certifier (Check only one)

🏡 Certifying Physician: To tha best of my knowledga, death occurred at the time, dete and plece, and dua to tha causa(s) and mannar as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

bresident PHYSICIAN

ROS0001

29c. License number

29d. Data signed (Month, Day, Year)

November 29, 1999

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Hiplims Bayview Medical Conten

complately

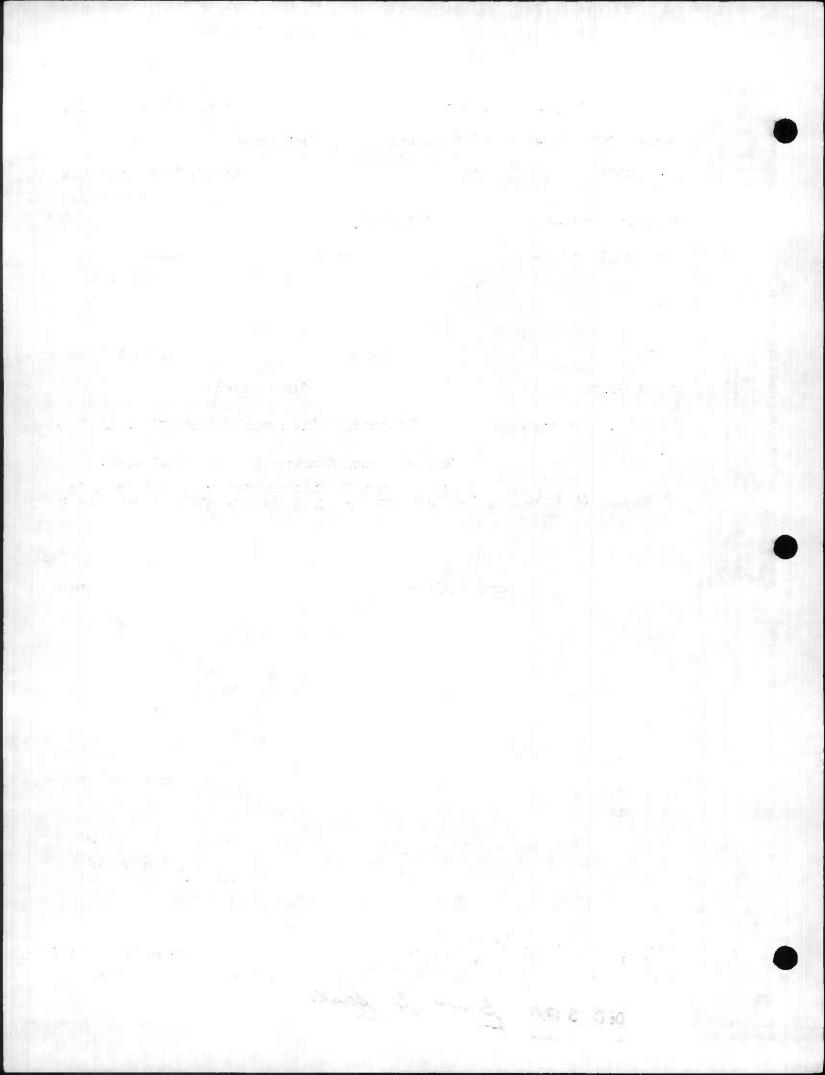
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DEC 3 32. Redistrer's Signature

Registrar

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Certification: To

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law requires that the death certificate be executed should ! certificate has b lirector, page 2 s Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifica 24 hours To the Hosp within 24 hou To the Funer completely fil

> State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year)

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30. Name end eddress of person who complated cause of deeth (Itam 23a) (Type, Print)



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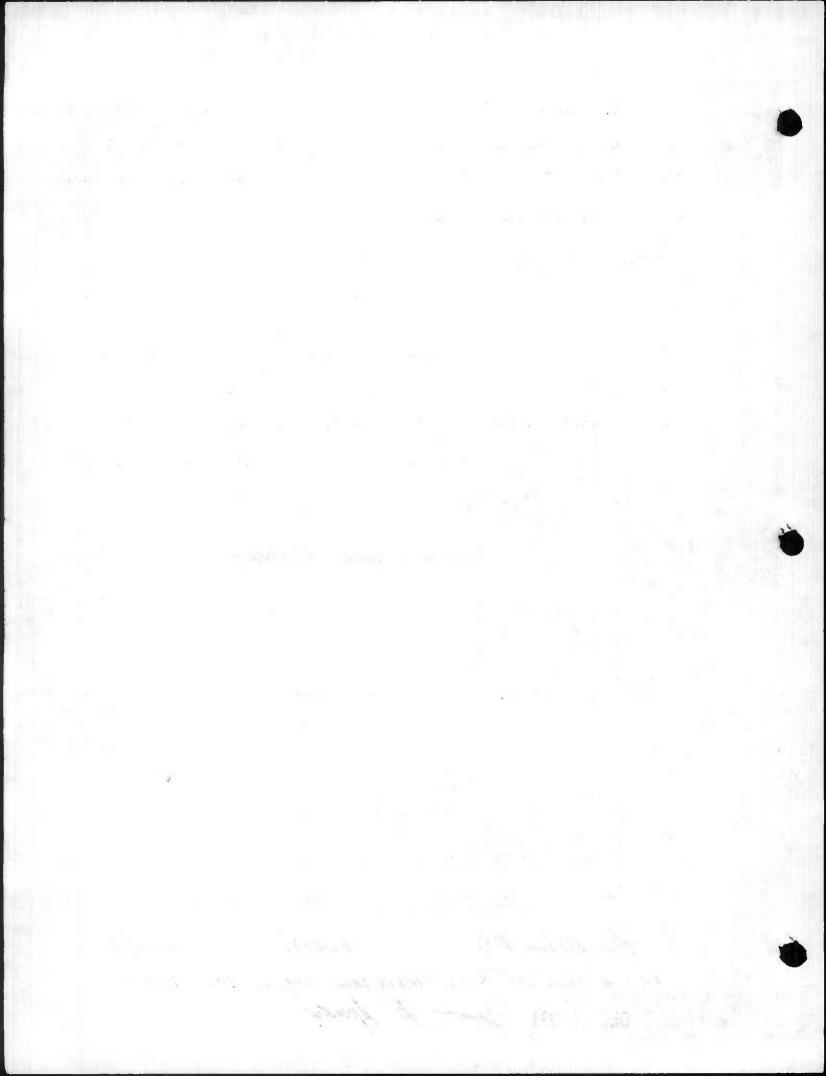
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Physic /Med	icai	Decedant's Nema (First, Middla, Herman L. Lil Aa. Facility Nama (If not institution,		4	b. City, Town			Day ber 24,	Day Year r 24, 1999 1:10 p					
Funera Directo	F	Mariner Health	of Greate:	r Lau	rel :. last birthday) Yrs.	If Und Months	ar 1 Year	Laure	Hrs. 8	Deta of Bir (Month, Da	Pri	9. Birthp	eorge placa (Stata or Foreign try) yland	
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ith the Maryland or 28a-f show	Director	10e. Street and Number	e George	George Laurel 101. Zip Coda							10g. Citizan o	f What Cour	1X Yes 2 □ No	
5-0020 72 hours efter death with the Maryland naturel', or items 23a or 28a-f show sites Examinet must be not the dist	by Funeral	7700 Cherry Lan 11. Markal Status 1 Navar Married 2 Marrie CWWidowed 4 Divorced	12. Was Dacada Armed Force	es? [2] No	If	Vas Dec Yes, sp	20707 Decedant of Hispanic Origin? (Specify Yes s, specify Cuban, Maxican, Puerto Rican, at Yes Yes 2 No Specify:			fy Yes or No can, atc.)	USA 14. Re BI	ace - Amaric ack, White, ify: Wh		
Am C . M	Be Completed	15. Dacadant's (Spacify only highast Elamantery/Secondary (0-12) 7	grada complated)	ducation ducation and a complated) Collaga (1-4or 5+) 16a. Dacedant (Give kine life. DO			sual Occupation work dona during most of working rusa ratired) an Expert				16b. Kind of	Businass/ind		
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than any injury or other treumatic event, in Mental Hygiene.	To Be	17. Fathar's Name (First, Middla, Le Edward M. Lille						Lily	V. E	Pugh	, Maiden Sume			
and 2 shr lealth and m 27 is m		19a Informant's Name/Ralationshi Chester L. Lill			P.O.	Box	185,		ge, M	laryla	er, City or Tow nd 2076	53		
Baltimore, semit. Pages 1 ar apportant: if Item; myortant: if Item; my injury or other.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Othar (Spe								Data . / 26	20c. Location - City or Town, Stata Laurel, Maryland			
Ball permit Depen import		21. Signature of Funeral Service Lie	11/	o ko		File	ale Fre	s of Fecility neral	Home	, Inc	Laural	Mary	land 20707	
Physician /Medical Examiner		23a. Partt. Enter the disease, or or shock, or heart failure. List or immediata Cause (Final disease or condition resulting in death)	a	CER	th. Do not enta BROVA or as a consequ	AS CU	LAK				rrasi,		Approximate Interval Batween Onsat and Deeth	
Box 68760, leath certificate be executed ettending physician and 1 for use as the buriet-transit	VMedical Examiner	Sequantially list conditions, if any, leeding to immediate causa. Entar Undarlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Last	c	Dua to (or es a consaqu	uanca of):							
by the	Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.								23b. Did tobacco use contribute to the cause of death				
Records, he law requires e hes been sign age 2 should be	Completed by									perfo	en autopsy ermed?	eve cor of c	ara autopsy findings bilabla prior to mpletion of causa daath?	
	BeC	25. Wes casa raferred to medicel axaminar?		26. Place of Deeth (Check only ona)										
ng Ph ng Ph neral	P	1 Yas 2 No 27. Manner of Daath 1 De Neturel 5 Pending 2 Accident Invastigat	28a. Data of I (Month,	28a. Data of Injury (Month, Dey Year) 28b. Tima of Injury et Work?					1	Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 28d. Describe how Injury occurred				
Division To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Certification:	3 Suicida 6 Could not determine	28e. Place of building,						28f	28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)				
Di To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	edical	29a. Certifiar 1 Certifying I (Check only one) 1 Certifying I 2 Medical Ex	Physician: To the be aminer: On the basis and mannar	of axamine	owledga, deeth etion end/or Inva	occurred	at the time	e, dete end p Inion, daath o	lace, and occurred	due to that at the time,	ceusa(s) and n date and place	nannar as st , and due to	ated. tha ceuse(s)	
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5		30. Nama and addrass of person wh	o complated cause of	f daath (Itan	CHER,	RY L	ANE	ZAUN	loc	mb	. 20	707		
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DHMH 16 Rev 6/95



Joshua AME

CHEND II	'EMS: #23 PART I		- FE	ertificate	of I	Death	14-	2. Data of De		9 (3 7 8 2 2 3. Time of Death	
Physician /Medical	Jo	shua Nevin Lon	g					Month Novemb	per 30	1999	11:20 AM.	
Examiner	4a Facility Nama (If not institution, giver Parking Lot /	a street and number) 3004 North Ri	dge I	Road	-			cation of Deat	h 4c. County	of Death		
Funeral Director	5. Social Security Number 6. S 219-68-6990	7. Age (In yrs. 28	last birthd	Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da SEPT 10	th ay, Year) 5, 1971	9. Birthpla Countr Mary	aca (Stata or Foreign	
Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland tent of Health and Mental Hyglere. nt: If item 27 is marked other than "natural", or itema 23a or 28e-f show my or other traumatic event, the Medical Examinat must be notified at To Be Completed by Funeral Director	Usual Rasidenca of Decedant 10a. Stata 10b. County		Town	r Location							d. Inside City Limits	
	MD Howard	_				10	1 ☐ Yas 2 No					
	10a. Street and Number 8800 Baltimore	Street		10f. Zip	0 7 6	53			10g. Citizen of 1	What Countr SA	ry?	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	S. 1	13. Was Decede If Yes, special 1 Yes 2	fy Cuba	ispanic Ori n, Mexicar Specify:	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	acity Yes or No- Rican, etc.) 14. Race - American Black, Whita, etc Specify:				
pemnit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiere. Department: if item 27 la marked other than "natural", any holury or other traumatic event, it a Haddell En		15. Decedant's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+)					t of work	ing	16b. Kind of B			
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Mental H Mental H arked ott atic ever	Herbert S	III]	E11e	en Bei	irst, Middle, Maiden Surnama) Beinert				
nd 2 sh sith and 27 is rr r trsur	19a. Informant's Neme/Relationship (Ellen B. Long/		19b. M 880	Address O Balt	(Street i	ore S	St.,	al Routa Numb Sava	er, City or Town, ge, MD	Stata, Zip C	² 63	
ages 1 and of Heart: If Item y or other	20a. Melhod of Disposition 1 Burial 2X Cramalion 3 Ramoval from Stata 4 Donalion 5 Other (Specify) 20b. Place of Disposition (Nama of commatary, crematory or other place) Metro Crematory, Inc. 12/02/99 Baltimore, MD											
permit. P Departme Important any injuri pacs.	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of Maryland, Inc.											
01	23a. Part1. Entar tha disease, or com shock, or haart failure. List only	plications that caused the death	n. Do not							1	Approximata Intervel Between Onset and Death	
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icate physical sthe	Cause (Disaasa or Injury that initiated events rasulting in death) Last	Dua to (or as a consequence of):										
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ires that the deeth certi signed by the attending d be detached for use e d by Physician/M	Part II. Other significant conditions of	Part II. Other significant conditions contributing to death but not rest						23b. Did tobacco use contribute to the cause of death' 1 Yes 2 10 No 3 Probably 4 Unknow				
v requires been sign should be										24a. Was an autopsy performed? 24b. Were eutops available prio completion of		
The law requir								of death?				
	25. Was casa rafarred to medical examinar?		h (Check only	one)								
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To the Hospital or Attanding I within 24 hours after death. To the Funeral Director; After completely filled in by the funer completely filled in by the funer Medical Certification.	3 ∑ Suicide 6 ☐ Could not b 4 ☐ Homicide datarmined	28a. Place of Injury - At he building, atc. (Specif) IN CAR	FOU	ND: P	PARKING LOT			3004 1				
To the Hospital within 24 hours a To the Funeral Completely filled		ysician: To the best of my knowninar: On the basis of examinet and manner stated.						end due to the		anner es sta	tha cause(s)	
Me Me	29b. Signature and title of certifier	. 1.		29c.	License	e number			29d. Date signe	d (Month, D	Day, Year)	

Phy /M

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

29c. License number O.C.M.E.

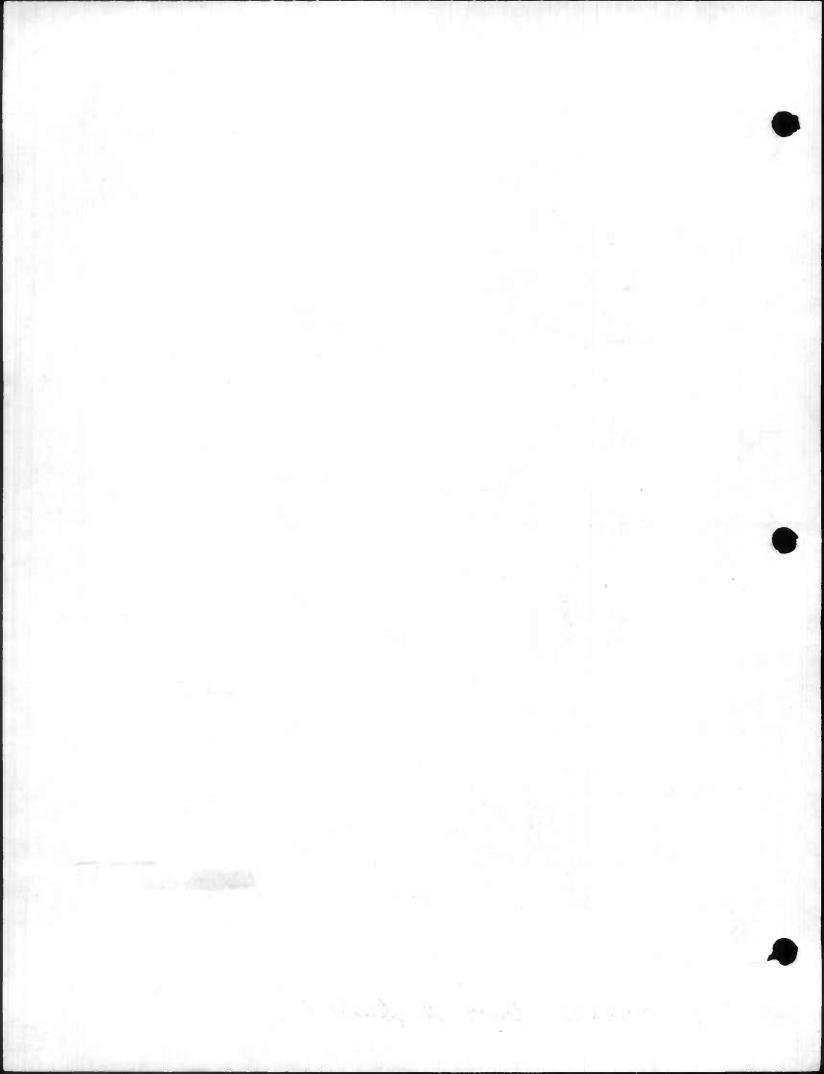
December 1, 1999

id address of person who completed causa of death (Item 23a) (Type, Print)

Loon

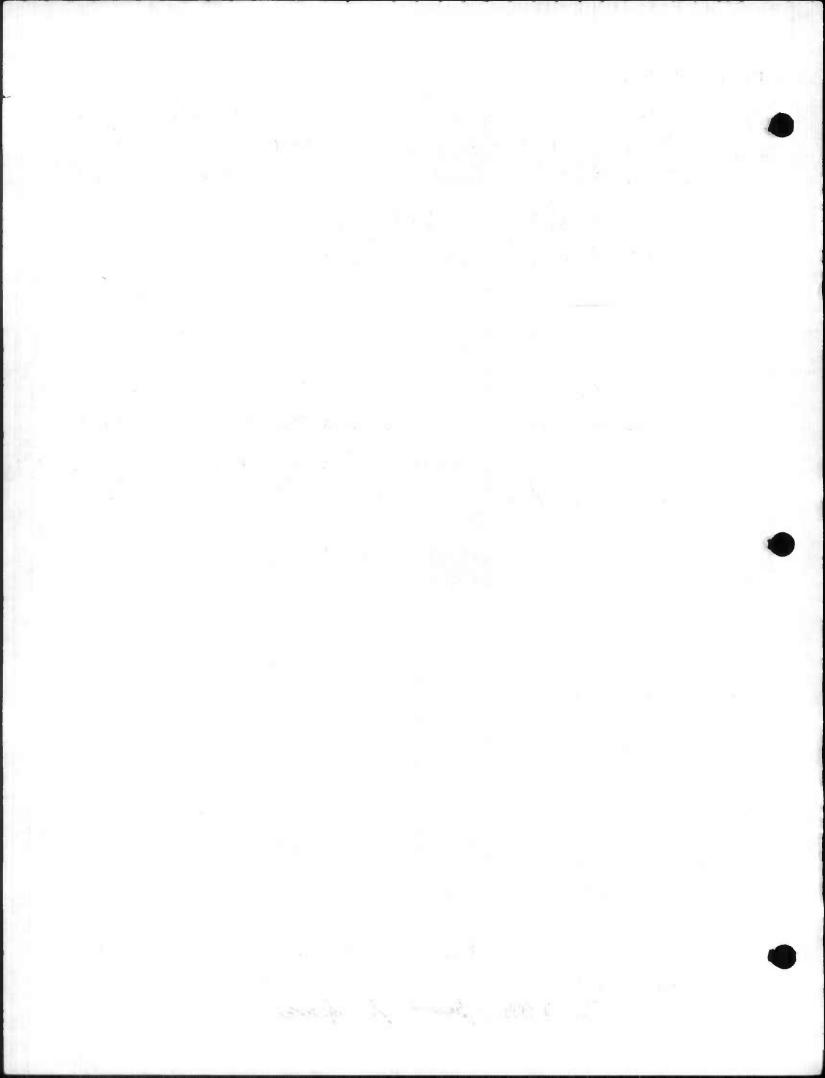
111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filed (Mortth, Day, Year) DEC 0 3 1999 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland	/ Department of H	lealth and Mental	Hygiene 99	37823
AMENDED ITEM #11 PE	ER FH G778 12/21/99 AH 1. Decedant's Nama (First, Middla, L	ast)	Certificate of	Death 2. Data	Reg. No.	3. Tima of Death
Physician	Mogog	Lewis		Mont	n Day Y	aar
/Medical	As all all bloom offered to all all			NOV.		
Examine	3701 Ferna	ale AVR		Baltimon	- 1	14
Funeral	001	Sex 7. Aga (In yrs. las	- Monthe Dave			Birthplaca (Stata or Foreign Country)
Director	Usual Rasidance of Dacedant	43	5 Yrs.	9	6 1934	North Carolin
how	10a. Stata 10b. County	10c. City.	Town or Kocation			10d. Inside City Limits
S Ma	Md. N	A 13	altimore			1 1 1 1 1 No
020 urs after death with the Ma ii, or items 23s or 28s-f s charding must be notified by Ettinarial Director	10e. Street and Number	adala Aug	10f. Zip Coda	1	10g. Citizen of Wh	at Country?
m 23 metal	11. Marital Status	12. Was Decedant Evar in U.S.	13 Was Dacedent of H	LO /	or No. 14 Baca	Amarican Indian,
or item	1 Navar Marriad XX Married	Armed Forcas? 1 ☐ Yas 2 ☐ No		lispanic Origin? (Specify Yas o an, Maxican, Puarto Rican, ato	Black,	Whita, atc.
ours ours		If Yas, Giva Yaar or Datas:	1 □ Yas 2 10 No	Specify:	Spelit	merieun
1 21215-0 ed within 72 ho ygjene. Per than "netur it, the Mod cell it.	15. Decadant's E (Specify only highest g		18a. Decedent's Usual Occup (Giva kind of work dona lifa. DO NOT use retired	during most of working	16b. Kind of Bush	nass/Industry
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be filed that Hygher a seem,	17. Fathar's Nama (First, Middla, Las	4)	J SCALLY C	18 Mothar's Name (First, M	iddle, Maiden Surnama)	1
ylai ould b Menta arked	Emanue L	Lewis		Josephin	e Parke	r Lewis
Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other treumatic event, the Medical Examinat must be notified at sone. To Be Completed by Figures i Director	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addrass (Street	and Number of Rural Routa	lumber, City or Town, St	ata, Zip Code)
Fey Heal other	20a. Mathod of Disposition	20b. Pla	ce of Disposition (Nama of	; 104 Laure	20c. Location - Ci	ty or Town, State
Peges ry or IT P	1 Burial 2 Cramation 3	Hemoval from Stata	natary, crematory or other place	12/1/9	9 Main	as Mills Md
Baltimore, permit. Peges 1 er Department of Hea Department of Hea Important: if Nem any Injury or other	21. Signature of Funaral Sarvice Lice		22. Nama and Addra	ss of Pierry CSDLV	eral Hoi	ne
m 88558	Joseph,	L. Russ	Joseph L	North ave	Balton	16.91216
	23a Perit. Enter the disaasa, or con	nplications that caused tha daath.	Do not antar tha mode of dyin	ng, such as cardiac or raspirat	ory arrest,	Approximata interval Batween
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68760, ficate be exported to the purial set the burial edical E	Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated events	c				
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o dea the eff	Part II. Other significant conditions	contributing to death but not rasuiti	ing In the underlying cause giv	an In Part I. 23b.	Did tobacco use contr	bute to the cause of death?
					1 ☐ Yes 2 ☐ No 3	☐ Probably 4☐ Unknown
Division of Vital Records, for Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by				24a.	Was an autopsy	24b. Wara autopsy findings
II Record The law requir ate has been s page 2 should					performed?	avaliable prior to complation of cause of death?
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Vital Fuctor. The certificate rector, pag	25. Was casa rafarred to medical axaminar?			26. Placa of Death (Check	only one)	
Of Vita Physician: this certific rial director,			NOutpatient 3□ DOA Oth	41 Iduising Homa 52		
On Oil II.	1 ☑Natural 5 ☐ Pending 2 ☐ Accidant Invastigatio	(Month, Day Year)	8b. Time of lnjury 28c. Injury Work	yat k? Yas 2 □ No	ribe how injury occurred	
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Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be		and mannar stated.	29c. License	a number	29d. Data signed (Month, Day, Year)
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X	30. Nama and address of person who		3a) (Type, Print)		1-10-1	V 1
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State Registrar	31. Data filed (Month, Day (Year)	3 1999. Registrar / Signatur	en & Sp	acks		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month **Physician** ANNIE MEYERS 10.45 pm 1999 NOVEMBER 26 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimore V/A Kospital Harbol If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth (Month) Dey. 5. Sociei Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** 10 M 20 F 247-68-0470 Yrs. Director Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Moorcal Examples must be not the disund. 1 Yes 2 No Director 10e. Street end Numbe 10f. Zip Coda 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Hastlib and Mental Hygiene.

In permit if Item 27 is marked other than "natural", or Items 23a or in marked other than "natural", or other than the lovent, its Moore that when the second of the Moore that when the second of the Moore that when the second of the Moore that when the second of the Moore that when the Moore that when the Moore that when the Moore that when the Moore that when the Moore that when the Moore that when the Moore that when the Moore than the Moore that when the Moore th 21239 U.S. 5609 by Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Bleck, Whita, etc. 1 Never Merried 2 Merried 1 Yes 2 de Baltimore, Maryland 21215-0020 1 Yes 2 No Specify 3 SWidowed 4 □ Divorcad Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Eiementery/Secondery (0-12) Coilege (1-for 5+) TIURSino IA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be minnie Dreher 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3429 Shannon Uz. BAltiMarc 20c. Location - City or Town, Stete Melinda 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) Date 20e. Method of Disposition 1 Buriai 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme and Address of Fecility. Home Baltimore, mol. 21213 CAroline 5+. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart feiture. List only one cause on each line. Approximata Intervai Between Onset and Death **Physician** /Medical Immediate Cause (Final 3 years Metastatic disease or condition resulting in death) Colen Examiner Due to (or es e consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b, Did tobacco use contribute to the cause of death? been signed by the a should be detached 1 Yes 2 No 3 Probably 4 Unknown Interinal obstruction by 24b. Were eutopsy findings available prior to completion of cause of death? Completed Hypertension 24e. Wes en eutopsy AZ No 1 Yes 2 No 1 ☐ Yes or Attending Physician: director, 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes a No 11 Inpatient 2 ☐ ER/Outpetienf 3 ☐ DOA Certification: To funeral 27. Manger of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No after death.

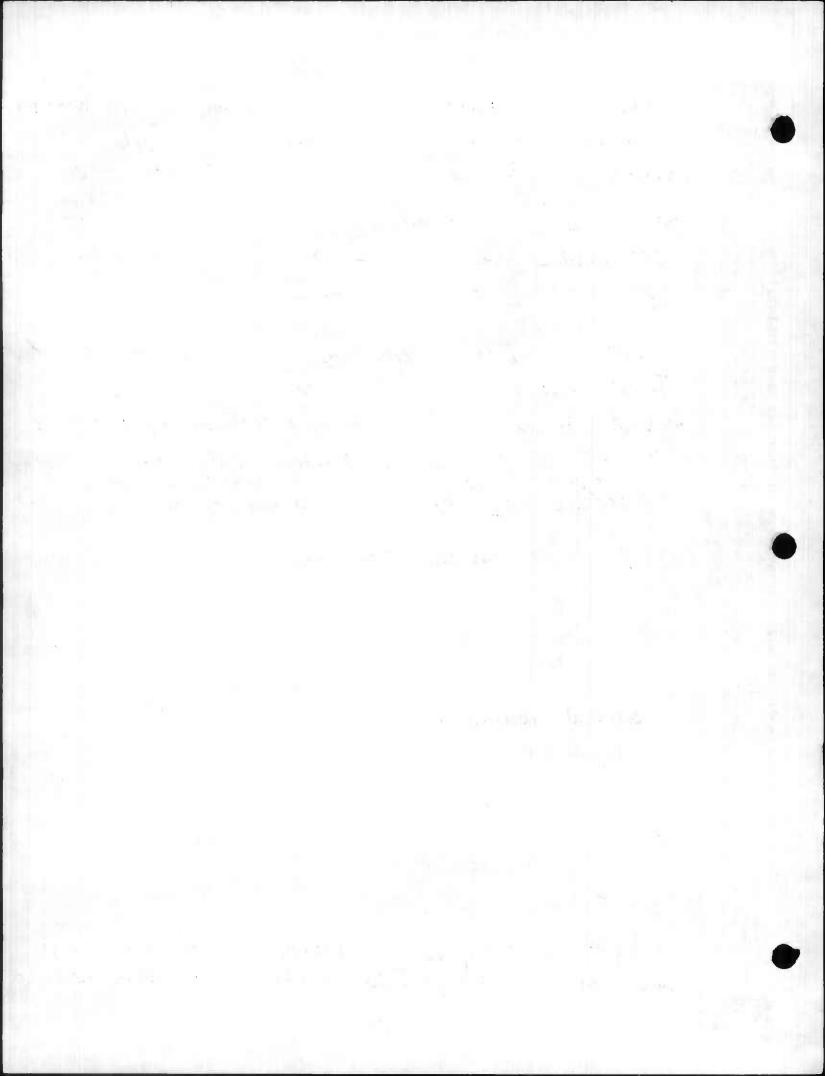
Director: A investigetion 2 Accident 6 Could not ba 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Piece of fnjury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours aftar To the Funeral Direcompletally filled in b 12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piaca, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted. 29e. Certifier Medical 29c. License number 29d. Data signad (Month, Dey, Year) 29b. Signeture end title of cartifiar 11949 NOVEMBER 26 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Moghekar, Karbor Kospital Center, 3001 South Hanouer St, Baltimore. MP-21225 Abhay 31. Data filed Wonth, Day (Year) 32. Registrer's Signature State DEC 03 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 99 Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Dev Month Year **Physician** FLOSSIE MOSES 19:15 HRS 30 Nov 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE, MD

If Under 24 Hrs. 8. Dela of Birth
(Month, Day, Year) OF BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Yaar Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Days Director 83 220-12-8252 S.C Usual Rasidence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 No Yas 2 No Director MD NA Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Brubar Ct Apt 1D
12. Was Decedent Ever in U.S. Armed Forces? therms 23a or iner must be ò Funeral 21207 U.S.A. 14. Race - Amarican Indien. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Maritel Status Black, Whita, atc. 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: ò 21215-0020 1 Yas 2 No Specify: þ 3 X Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Day Care Provider na Private Home Saltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumema) Pages 1 and 2 should be fill brant of Health and Mental Health and Mental Health and Mental Health fury or other traumatic even jury or other traumatic even Be Torrence Fortune Susanna Toney

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Department of Health ar Important: If Item 27 is any injury or other traus Rose Motley-Daughter 11 Brubar Ct Apt 1D, Baltimore Md 21207 20b. Place of Disposition (Nema of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20s. Method of Disposition Winnel 2 ☐ Cremetion 3 ☐ Removel from State Donation 5 Other (Specify) Arburn Cemetery 12/04/99 Baltimore, Md ura of Funaral Service Licenses 22. Nema end Address of Facility
March F/H West 2f. Sign Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, or haert failure. List only one cause on each line. 21215 Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Septicemia diseesa or condition rasulting in deeth) Examiner Due to (or as a consequence of): Examine Infection Tract ilcian and burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) physician s the buria Box 68760. neumonia Physician/Medical Due to (or es a consequence of): 88 080 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES Records. by 24b. Wara autopsy tindings aveilable prior to completion of causa of death? 24a. Was an autopsy performed? Completed HIGH BLOOD PRESSERF 1 Yas 2 No 1 ☐ Yas 2 No DEHTORATION certificate of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 28b. Tima of Injury 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) Certification: 28c. Injury at Work? Affer 5 Pending invastigation Division or Attending 1 Natural 1 Yas 2 No NIA 24 hours after death.

Funeral Director: A MA 2 Accident NIA 6 ☐ Could not be 3 □ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide NA NIA Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the tima, date and place, and dua to the cause(s) and menner stated. 29a. Certifier completely (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number Nov. 30, 1999 D43476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. BELVEDERE

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State

Registrar

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BRODERICK J FRANKLIN, MO

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31. Date filed (Month, Day, Year)

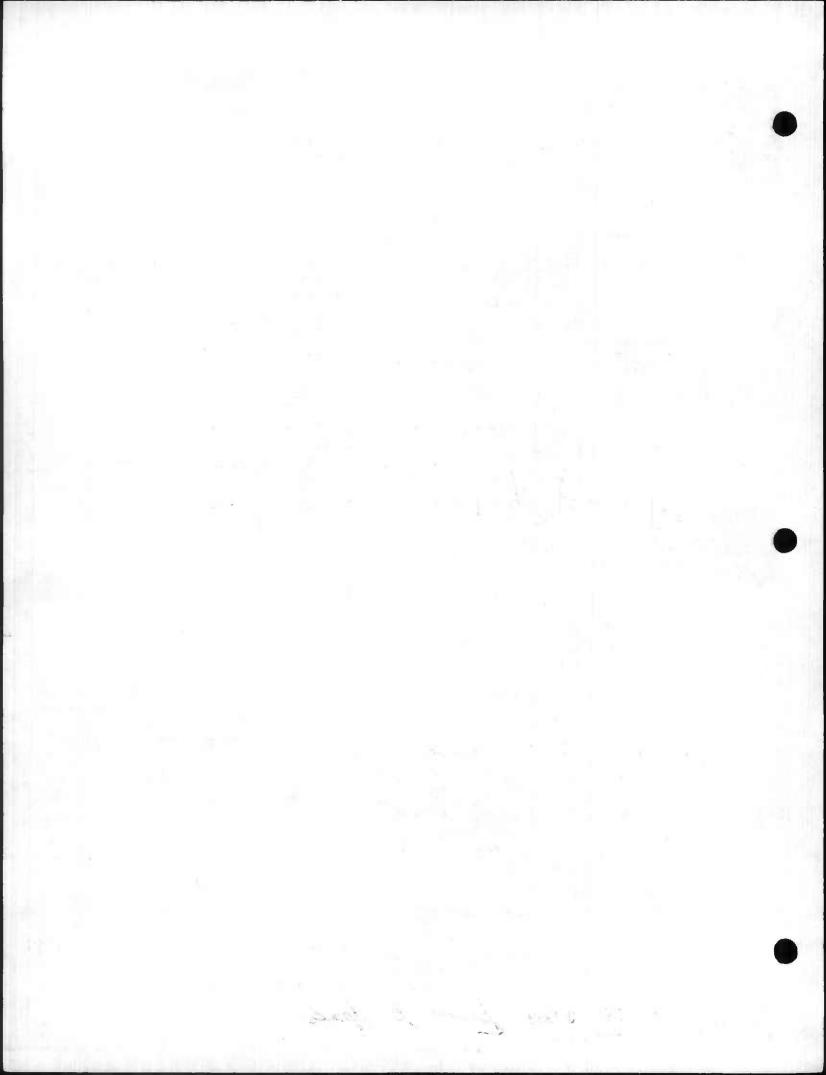
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32. Registrar's Signature

SINAI HOSPITAL OF BALTIMORE

BALTO, MD 21215



State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Dete of Death 3. Time of Death Day Year 1999 Physician DECEMBER 10:45 PM LORETTA CATHERINE MCCANN /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Saint Joseph Medical Center Baltimore Towson H Undar 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 5. Sociel Security Number Birthplaca (Stata or Foreign Country) **Funeral** Months 1 M 2 F 90 Yrs Director 207-18-9331 3/12/09 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10e. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner naut be notified at 1 ☐ Yas 2 No Director MD BALTIMORE CARNEY 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 6 238 2408 LAMP POST LANE 21234 USA Funeral Hems 12. Was Decedent Ever In U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Ricen, atc.) 11 Meritel Stetus 14. Race - Amaricen Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "netural" any injury or other traumatic even. Biack, White, atc. 1 ☐ Yes 24 ☐ No If Yes, Give Year or Detes: 1 Nevar Married 2 Married 1 Yes 2 X No Specify: by 3 X Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 7TH GRADE HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) Be PATRICK HOLMES KATHERINE MORTIMER 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER-IN-LAW IRMA MCCANN 2408 LAMP POST LANE CARNEY, MD 21234 20b. Plece of Disposition (Neme of cematary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) METRO CREMATORY, INC. 12/3/99 CATONSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWS

23a. Pert1. Enter the disease, or complications that usused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on a rational line. TOWSON, MD 21234 Approximeta Interval Betw **Physician** ASPIRATION PNEUMONIA ONE DAY /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In daath) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Dua to (or as e consequance of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the a should be detached 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown GASTROINTESTINAL BLEEDING Records, þ 24b. Were sutopsy findings evelleble prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE page 2 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 XNo certificate Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical 28. Pleca of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Yas 2 No s aftar death.

I Director: Aftar this of in by the funeral di Aftar this 27. Menner of Deeth . Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D complataly filled filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pieca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner stated. Medicai 29a. Certifier To the 29b. Signeture and title of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) D16492 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BEATRIZ P DIZON, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

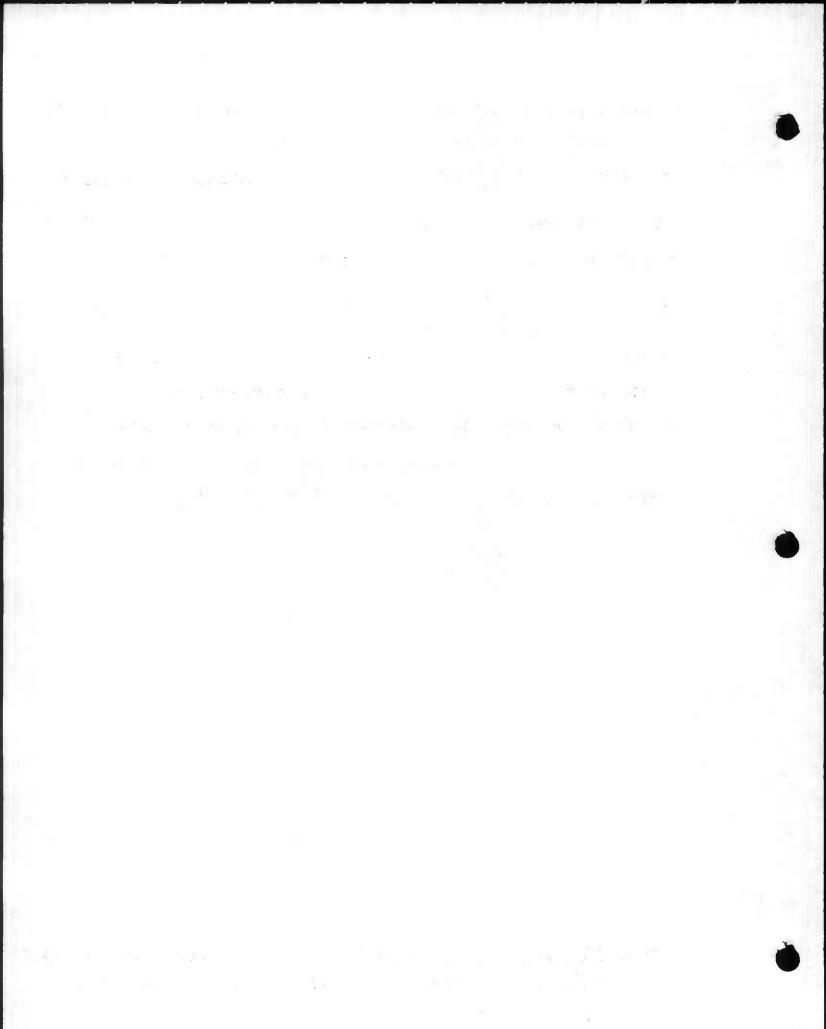
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State Registrar 31. Dete filed (Month, Day, Year)

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32. Registrar's Signeture



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HA	ARRISON	MC	SLEY III	State of	Marylan				lealth and M	Mental H	ygiene Reg. No.	19 3	7827		
	Physic /Medi		1. Decedent's Neme (First, Middle, Last) HARRISON MOSLEY III						2. Dete of Deeth Month Day Yaar 3. Tim		3. Time of Death 5:21 PM				
7	Exami	ner	4a Facility Name (If not institution, give street and number) 4700 GWYNN OAK AVENUE 4700 BALTIM							th 4c. Cou	inty of Deeth				
	Funeral Director		302-74-1357	ex 7	7. Age (In yrs. I	Adomi		1 Year Days	If Under 24 Hrs. Hours Min.	8. Dete of B	irth 9. Birthplace PALII.		ace (State or Foreig CMORE, MD		
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND		, Town or Loc						10	Od. Inside City Limits			
	94 28 04 28	Directo	10s. Street and Number				10f. Zip	Code				of What Counti	ry?		
Maryland 21215-0020 12 should be filed within 72 hours effer deeth with the Maryland in and Montel Hoplane.	ours effer deeth with the Maryler ral', or frems 23s or 28s-f ehow Examinar mast be notified at	by Funeral	4111 KATHLAND AV 11. Marital Status 1) Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Def	ces?				lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Bleck, White, e	FRO. AMERICAL ss/Industry FION CO. e, Zip Code) 21207 or Town, Stete		
	s within 72 hours jene. r then "naturel", the Medical Ext	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		4or 5+)	life. D	ent's Usuel kind of worl OO NOT use BORER	k done	during most of worl	king		RUCTION			
	be filed tel Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) HARRISON MOSL		271	ONLIN		18. Mother's Nem		e, Maiden Sun					
Aan	2 sho and h								and Number or Ru	ural Route Number, City or Town, State, Zip Code)					
Baitimore, N	of Heal		LYNNISE NORRIS 20a. Method of Disposition Disposition Donation 5 Other (Specify	MOTHER Removel from Si	tate	4111 lace of Disposementery, cremin	sition (Nam natory or ot	e of her plac		TIMORE Date	20c. Location	AND 212 on - City or Tow	wn, Stete		
Baiti	permit. Page Department of Important: If eny Injury or		21. Signature of Funeral Service Licen	- ELG		22. E:	Name and STEP 300 E	BRO UTAI	ss of Facility THERS FUN W PLACE	ERAL S	ER, P.	Α.			
	Physician /Medical Examiner		23a. Part1. Enter the desease, or com- shock, or head failure. List only timmediate Cause (Finel disease or condition	one cause on ed		. Do not ente	er the mode	of dyir	ng, such as cardiac	or respiratory	errest,		Approximata Intervel Between		
	15 h	5	resulting in death)			as a consequ						1			
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ox 6876	certifice iding ph	n/Medical	that initiated events resulting in death) Last	d	Dua to (or	es a consequ	uence of):								
P.O. B	by the	Physician/M	Part It. Other significant conditions or	ontributing to dea	th but not resu	Iting in the un	derlying ca	use giv	ren in Pert I.		tobacco use		the cause of death		
of Vital Records,	s been sign 2 should be	Completed by									s an autopsy formed?	avai	re autopsy findings ilable prior to npletion of causa leath?		
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Vita	Physician: The this carificate risi director, pages	Be	25. Was case referred to medicel axaminer?	Hospitel:				Oth	26. Place of Dea				0077		
	Phys rel di	5. To	XXYes 2 No 27. Manner of Death	28a. Dete of		ER/Outpatient 28b. Time of		Sc. Injur	4 LI Nursing In		how injury oc		SCENE		
ion	Attending Ph or death. ector: After th by the funeral	atio	1 □ Naturat 5 □ Pending 2 □ Accident investigation	11-26-		1707		1 🗆	k? Yes XXNo	SUBJE	CT SHOT	2			
Division	5475	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28a. Place of building	of Injury - At ho g, etc. (Specify	me, ferm, stre	et, fectory, EET			4760°G	WYNN OF	K AVEN			
	To the Hospital within 24 hours of To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1☐ Certifying Phy	ysician: To the b liner: On the bas	ds of examineti	vledge, death ion end/or inv	occurred a estigation,	t the tin	ne, date end place, pinion, deeth occur	and due to the red et the time	e cause(s) and , deta end ple	thanner as sta ce, and due to	tha cause(s)		
	To the compl	Me	29b. Signature and title of certifier	1/2/					e number .M.E		29d. Dete si	gned (Month, D			

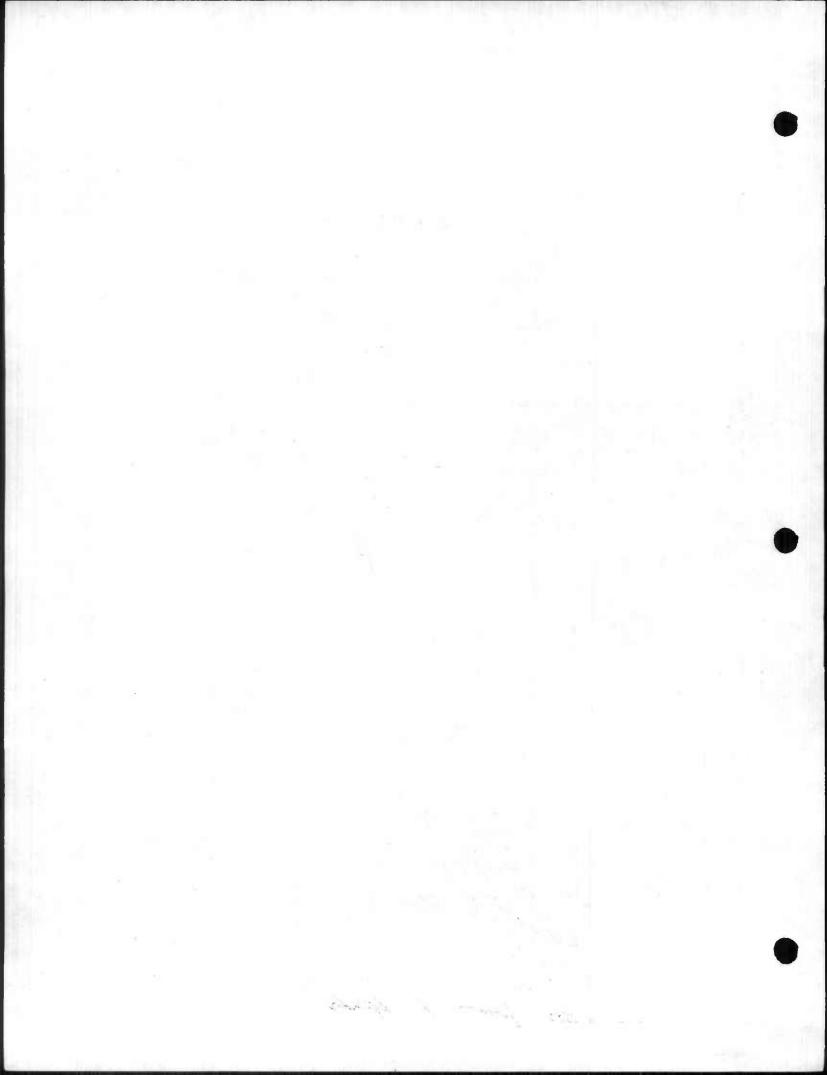
State Registrar

31. Date filed (Month, Day, Year)
DEC 3 1999

32 Registrar's Signetura

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Nam A R Fauler 111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death Day Month Year William 29, P. McCloskey 1999 4:20Am November 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 7661 Beth Noelle Court Pasadena Anne Arundel If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 5 1935 If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days 202-26-7834 64 Pennsylvania Usuel Rasidence of Decedent 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2XTNo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1488 Thies Drive 21122 USA 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 ⊠ Yas 2 □ No If Yes, Give Yaar or Datea: 1 Never Married 2 Merried specify: White 1 Yea 2 No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busineas/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Electrican(Superintendent) Steel Industry 17. Fether'a Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John A. McCloskey Valeria Tharp 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Karen J. Halcombe (daughter) 7661 Beth Noelle Ct., Pasadena, MD.21122 20a. Mathod of Disposition 20b. Placa of Disposition (Neme of cemetery, crametory or other place) 20c. Location - City or Town, Stete December 1 XBurial 2 Cramation 3 Removel from State Glen Haven Cemetery Glen Burnie, Maryland 4 th 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Lifensee 22. Nama and Addrass of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 net caused tha daath. Do not enter the mode of dylng, auch as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the diseesa, or complications shock, or heart failure. List only one cause Approximate interval Between Onset and Death Immediate Ceusa (Final Small Cell Luny Cancer disaasa or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No history of Colon Cancer 1990 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Lyng Cancer 1990, Prosta 24a. Was an autopsy 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Jaughte Othar: 4 Nursing Homa 5 Residence 6 Dother (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatiant 2 ER/Outpatient 3D DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Netural

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or hema 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at

aitimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records.

the burial-transit

Examiner Physician/Medical ate has been signed page 2 should be de Be Completed by certificate funaral director, edical Certification: To this After

or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by

Registrar

DHMH 16 Rev 6/95

State

2 Accidant

3 Suicide

29a. Certifier

4 Homicida

29b. Signature and utla of certifier

11/Data filed (Month, Dey, Year) DEC 03 1999

6 Could not be determined

1600 32. Registrar's Signetura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAAA

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

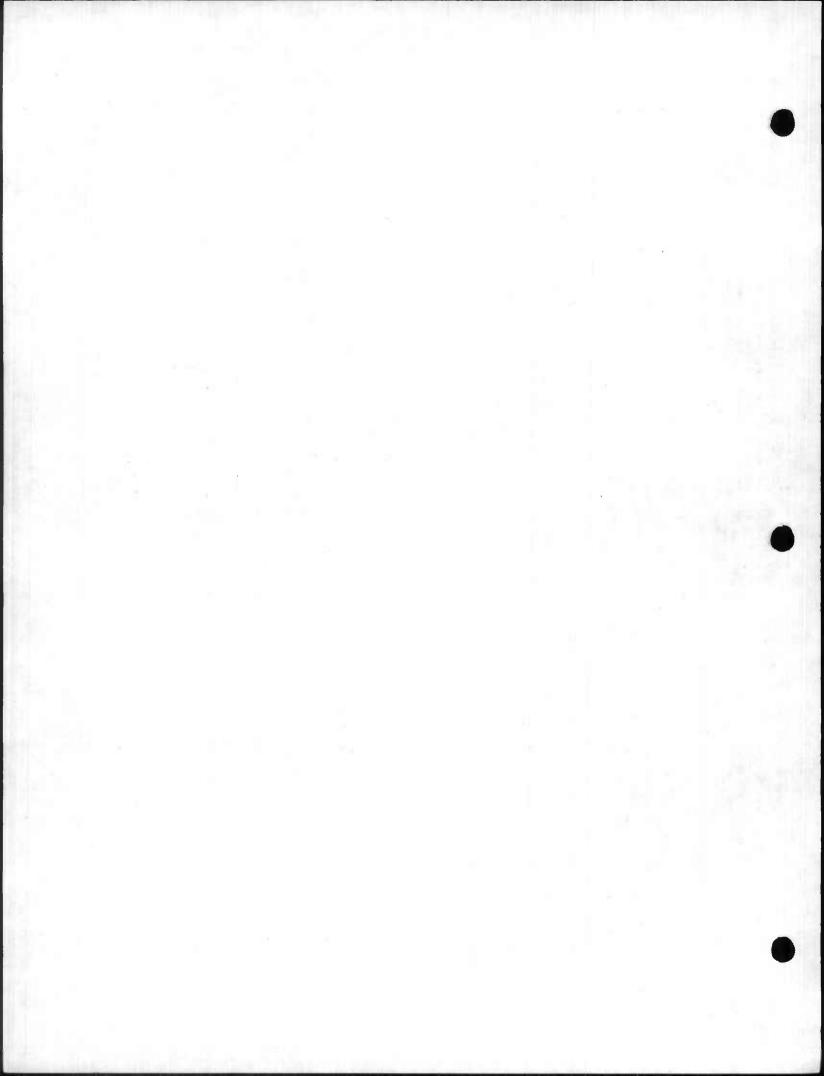
😕 Certifying Physician: To the best of my knowledge, daath occurred at tha time, data and place, and due to the cause(a) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stelled.

29c. License number

1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

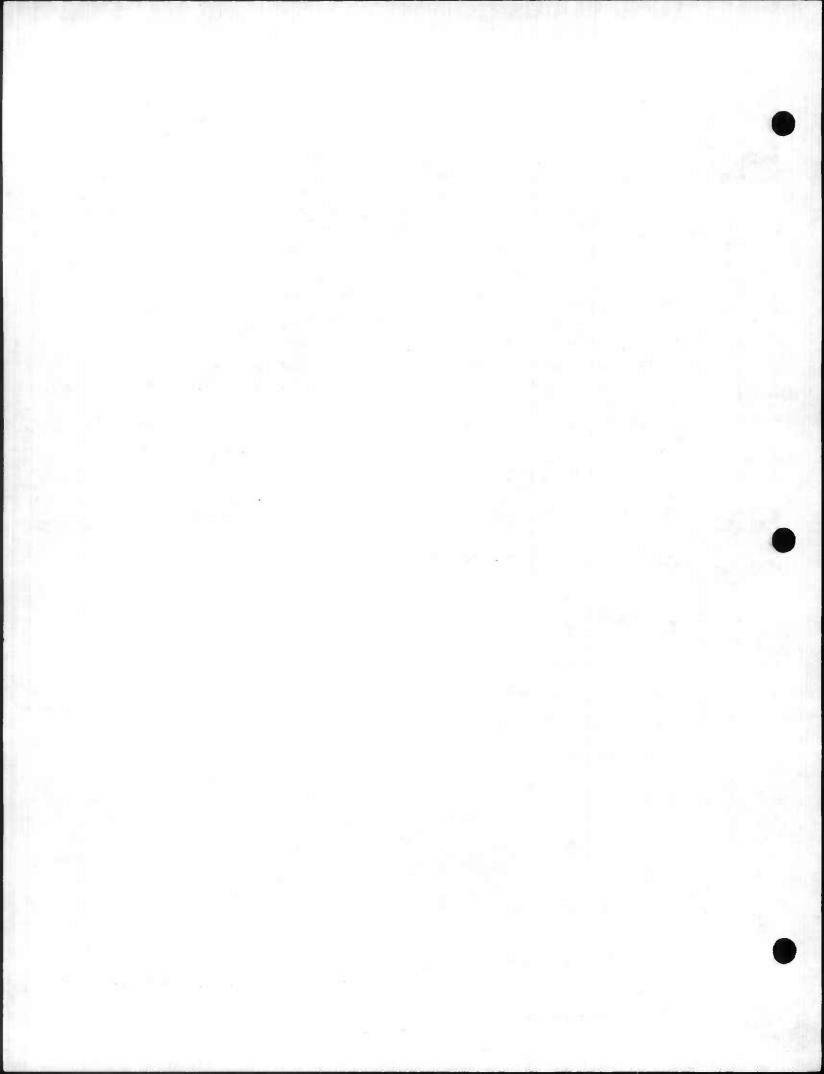


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

WILMA			State of Maryland			ental Hygi	ene	070	00		
NIEDOBA		Decedent's Name (First, Middle, Last)	Certificate of	Death	2. Date of Death	g. No. 3	3 / B	e of Death		
Physicia	_	WILMA	NIEDOL	3A	1	Month DECEMBER	Day 1,199	Year	P.M.		
/Medic Examin		to Facility Name (March politicism minutes) and a second political facility of Pacific Name and application of Pacific Name and application of Pacific Name and application of Pacific Name and application of Pacific Name and application of Pacific Name and application of Pacific Name and application of Pacific Name and application of Pacific Name and Application of Pacific Name an									
	_	1528 RITA ROAD		DUNDALK		BALTI	MORE				
Funeral Director		5. Social Security Number 316-28-6993 Usual Residence of Decedent	7. Age (In yrs. last	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	1931	9. Birthplace (Sta Country) PCNN	te or Foreign		
Maryland a-f show iffed at	ctor	10a. State 10b. County MD. BALTI		OUNDALK					e City Limits		
er death with the Maryt Nerns 23s or 25s-! sho ther must be notified at	I Director	10e. Street and Number 1528 RITA	ROAD	101. Zip Code	1222	109		Vhat Country? S.A.			
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of It fee, specify Cub 1 ☐ Yes 2 No		cify Yes or No- Rican, etc.)	Biac	e - American Indian k, White, etc.			
21215-0020 d within 72 hours all pleys. r than "netural", or the Medical Exam	Be Completed	15. Decedent's Edu (Specify only highest grad	cation 1 (cation e completed) College (1-4or 5+)	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire HOME MA	during most of working	g		HOME			
aryland and Mental Hy and Mental Hy and Mental exem,	To Be C	17. Father's Name (First, Middle, Last) JOSCPH	KONOPKA		18. Mother's Name M INNA	AB	OWN HOME Maiden Surname) BRAH AMOWSKI City or Town, State, Zip Code) BALTO. MD 21219 20c. Location - City or Town, State BALTO. MD. ME OF OWN LOKK R. BALTO. MD 2122				
Baltimore, M. permit. Pages 1 and 2 Department of Health a Important: If them 27 is any injury or other tra page.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CONNELLY FUNERAL HOME OF DUNGLIK TILD SOLVETS PoinT R.D. BALTO. MD 2122. 23a. Part! Enter the disease, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
Physician /Medical Examiner	er	Immediate Cause (Final	Arteriosclerot	J				Onset a	nd Death		
8760, sate be executed physician and the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
Box 68760 feath certificate be e	n/Medical	Cause (Disease or injury that initiated events resulting in death) Last									
P.O.	Phy	Part II. Other significant conditions cor	tributing to death but not resultin	ven in Part I.	23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknow			es of death?			
Hecords, ne law requires to s has been signe tge 2 should be to	Completed by					24a. Was an performe INSPECT	ed?	24b. Were autop available pr completion of death?	ior to		
= F # &		OF INC.				1 ☐ Yes		1 ☐ Yes	2□ No		
Of VITa Physician: this certific and director,	To Be	25. Was case referred to medical examiner? Y Yes 2 No	lospital:	Outpatient 3 DOA Oth	26. Place of Death her: 4 Nursing Horr			er (Specify)			
		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		b. Time of linjury 28c. Injury Wo		8d. Describe how					
DIVISION or Attanding after death. Director: Afte d in by the fund	Certification:	3 Suicide 6 Could not be determined	28e. Piaca of Injury - At home building, etc. (Specify)	, farm, street, factory, office	2	8f. Location (Stre City or Town,		er or Rural Route I	lumber,		
2 5 4 3	edical		ilclan: To the best of my knowled her: On the basis of examination and manner stated.						se(s)		
To the To the comp		29b. Signature and title of certifier	20	29c. Licens	se number	290	d. Date signer	d (Month, Day, Yea	r)		
\wedge	_	Skuni J.C	hule		C.M.E.	DE	CEMBER	2,1999			
10			mpieted cause of death (Item 23: Me MD		Street, Ba	altimore	, Mary	land 2120)1		
Stat	e	31. Date filed (Month, Day, Year)	32. Registrer's Signature	, ,							

Registrar

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PHILLIPS TAMI FAYLENE 1999 9151 AM November 29 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE GOOD SAMARITAN If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Deys 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 39 Yrs. Birthplece (State or Foreign Country) M D 1 □ M 2 🖾 F 215-84-3967 09-17-60 **Usual Residence of Decedent** 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD XGYes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Bayonne Avenue 21214 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 基②No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yas or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify: 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry District Court of Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Fulltime 2yrs. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Levon Phillips, Sr. Ruth Edmonds 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jefferey Newkirk, Sr. 3320 Bayonne Avenue Baltimore, MD. 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 12-06-99 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue ben eren 23a. Fart1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feiture. List only one cause on earth line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel MENINGITIS CARCINOMATOUS disease or condition resulting in death) Due to (or as e consequence of): BREAST CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4€ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 Yas 2 No 26. Place of Death (Check only one)

physician and s the burlet-transit P.O. Box 68760, 8 been signed to should be det Records, Completed page 2 certificata Division of Vital or Attanding Physician: funeral director, Be Certification: To this After sftar death.

Physician

/Medical

Examiner

Funeral

Director

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Itams 23e or

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Physician /Medical

Examiner

Examiner

Physician/Medical

by

Director

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Completed

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72 hours after

21215-0020

altimore, Maryland

Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 25. Wes case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 ENetural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier

199 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number P12563

29d. Date signed (Month, Day, Year) November 29 1999

PCLELIA NEGRINI, M.D. 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Raven Boulcuard, BALTTORE MD 21239 CLELIA NEGRINI 31. Date filed (Month, Day, Year)

State Registrar

Illed in by

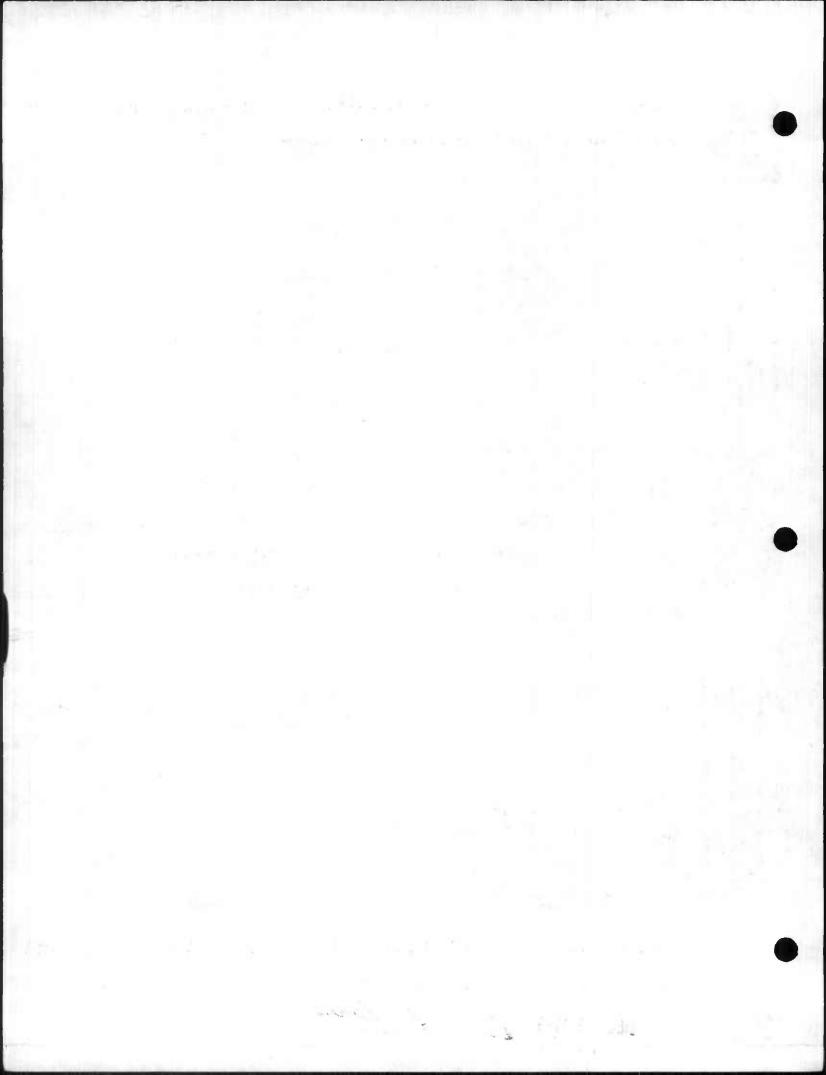
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To the Hospital within 24 hours a To the Funeral D completely filled

3 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. " 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 99^{Yaar} **Physician** NOV. 10:28am Purnell Anthony M. 28, /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimore 1113 Andover Road If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours **™** 2□ F 42 Yrs. MD 213-64-7093 Director Usuat Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ?? is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinet must be notified at Yes 2□No Director MD NA Baltimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21218 USA 1113 Andover Road Funeral 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No if Yas, Giva Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-tf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - Amaricen Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer begoment of Heelih end Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. 1 XNavar Marriad 2 Married 1 Yas 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) Kennedy Kriger Elemantery/Secondary (0-12) Collage (1-4or 5+) Institute 12th Grade Clerical NA 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) Purnell Mildred Roles Raymond 2 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 21218 1113 Andover Road Baltimore, Maryland Mildred Purnell 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata MD 20a. Mathod of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from State Cedar Hill Cemetery 12-03-99 Anne Arundel Co, 4 □ Donation 5 □ Other (Specify) 21. Signetura of Funaral Sarvice Licansas 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the diseese, or complishock, or heart failure. List on the complex of the comp Approximete Intarvel Batween Onset end Death bations that caused the deather cause on each line. to not antar tha mode of dying, such as cardiac or respiratory errast, **Physician** allianea. Immediate Cause (Finel vired diseese or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner ed by the ettending physician and deteched for use as the burial-transit Sequentially list conditions, if any, leeding to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daeth) Last Dua to (or es e consequence of): Physician/Medicai Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings evailable prior to 24a. Was an autopsy Completed completion of ceuse of death? 1 Yas 2 No 1 □ Yas 2 No director, Be 25. Was cesa raterred to madicat axaminar? 28. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 27. Mannar of Deeth 28a. Data of injury (Month, Day Year) 28b Time of Certification: 28c. Injury at Work? 1 Neturel 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28a. Ptace of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida

ANTHONY FLENEII

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Baltimore, Maryland 21215-0020

10:38 AM

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State Registrar

Medical

31. Data filed (Month, Day, Year) 3 1999

30. Nama and addrass of person who co

29b. Signature and titla of certifian

ed cause of death (Itam 23a) (Type, Print) veliw un 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledga, deeth occurred at tha time, dete and piece, and due to tha ceuse(s) end menner es steted.

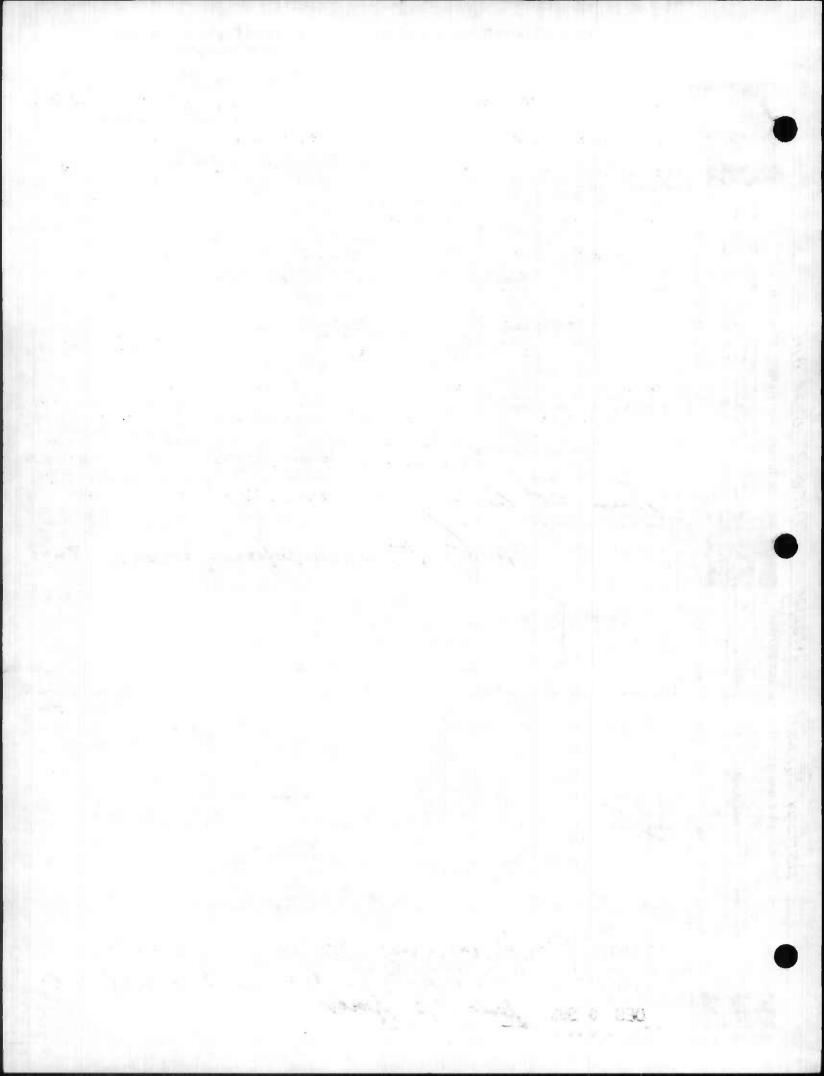
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner steted.

29d. Data signed (Month, Day, Year)

828 W. Eutaw St. B

29e. Certifier

(Check only one)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #1 PER MD G778 12/21/99 AH Certificate of Death 1. Decedant's Nama (First, Middla, Last) ANTHONY B. PUCCETTI, JR 2. Data of Death Month **Physician** 4:55AM Anthony B. Pucetti, Jr. November /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Mercy Medical Center Baltimore N/A If Under 24 Hrs. If Under 1 Yaar 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07.16.1953 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1/2 M 2□ F 216.58. 4587 Yrs. Director Maryland Usuat Rasidence of Decedant 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or itema 23a or 28a-f ahov the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3532 Noble Street. 21224 Items 23a USA Funeral Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after 1 Yas 2 No if Yas, Giva Nevar Married 2 Married 'natural', or altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Construction Dry Wall permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if Item 27 is marked other
any Injury or other traumatic event 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surnama) Be 2 Anthony B. Puccetti, Sr. Goldie May Shank 19a. Informani's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William Roger/ Cousin 3532 Noble St. Baltimore, MD 21224 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Balto.-Washngt. Crem. 11/30/99 Laurel, MD 21. Signatura of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Moran-Ashton-Dabrowski Fun'l Home Inc. Baltimore St. Balto. 3000 E. 23a. Part1. Entar tha disassa, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel Atron O to (or as a consequence of): disaasa or condition rasulting in daath) Cancer **Examiner** Examiner physician and s the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, taading to immadiate causa. Entar Undartying Cause (Disaase or Injury that initiated evants rasulting in death) Last Dua to (or as e consequence of): P.O. Box 68760 Physician/Medical Dua to (or es a consequence of) attending p 88 Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Ves 2 No 3 Probably 4 Unknown signed be det Records, þ 24b. Were autopsy findings available prior to completion of causa of death? been si 24a. Was an autopsy performed? Completed page 2 s 2/2 No certificata 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attanding Physician: 25. Was casa refarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) NOS/NIL 1□ Yes 2□ No Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Naturat 2 Accidant 5 Pending invastigation Aptal co.
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real Director: Atta 1 ☐ Yas 2 ☐ No 6 Could not be datermined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida in 24 hour. 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Funer completaly fil Medicai 29a. Cartifian

State Registrar (Check only one)

29b. Signatura and titla of cartifian

30. Name and addrass of person who

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29c. Licensa number

St Paul PI

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complated cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral	

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	Physician /Medica		PHILLIP	D.	ROBII					NOVEMBI	ER 27,	1999	1536 PM
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ti ti	or 28a-f	10	De. Street and Number	or				10f. Zip Code			10g. Citizen of	What Cou	ntry?
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Ords	hould be		Diabetes	WGTTT-EN	S						an eutopsy ormed?	81	Fere autopsy findings veilable prior to completion of cause
S S	8 64 0									INSPE	CTION Yes XXNo	of	death?
= -	certificate rector, par		: Was sons referred	to medical T								1	☐Yes 2☐No
Or Vital Physicien: T	his certificate hu director, page		i. Was case referred examiner? XIXI Yes 2 No	to medical	Hospital:	nationt 2	ER/Outpatien	VIN DOA O	26. Place of Deet		dence 6 Ott	/C	4.1
	2 -		. Menner of Deeth		28a. Dete of	Injury	28b. Time of	28c. Inj			how Injury occur		ny)
VISION	ector: After by the fune iffication		XXIatural 5 2 ☐ Accident	Pending investigation		Day Year)	Injury		ork? ☐Yes 2☐No				
5 8	10 E		3 ☐ Suicide 6	Could not be determined	28e. Plece of building	f Injury - At h	ome, ferm, stre	et, factory, office		28f. Location (- City or To		ber or Rui	ral Route Number,
To the Hospital	within 24 hours after To the Funeral Dir completely filled in Medical Cert	29	Pa. Certifier 1 (Check only One)	Certifying Phy Medical Exam	vsician: To the base	is of examina	wledge, death tion end/or inv	occurred at the estigation, in my	time, date end place, opinion, death occur	and due to the red at the time,	cause(s) and m date and plece,	anner as : and due !	stated. to the cause(s)
Toth	To th		1 / / /						cME		29d. Date signed (Month, Day, Year) NOVEMBER 28, 1999		
	Oth	30	Neme and eddress	ot person who	completed cause				Baltimore,	, Maryla	and 2120	01	
F	State Registrar	31	. Date filed (Month)	ECoar) 3	1999 32. Re	gistrat's Signa	eture	4 4	uls	-			
								7				-	

worls ! r than "natural", or items 23s or 26s-f shore the Medical Examiner must be notified at 1 and 2 should be filled within 72 hours after that the new Mentel Hyglene. em 27 la merked other than "natural", or fle Department of Haaith and Important: If Item 27 is meny injury or other traumonce. Physician

Physician

/Medical

Examiner

10a. State

Director

by

Completed

Md.

Funeral

Director

/Medical Examiner

Examine physicien and the buriai-transit The lew requires that the death certificate be axecuted Physician/Medical US 88 á page 2 should b Completed or Attending Physician: funeral director, e Certification: To this After after deeth. 6 To the Hospital of within 24 hours at To the Funeral D completely filled

Box 68760. P.O. Records, of VItal Division

29a. Certifier (Check only

29b. Signature and title of certifier

Michalle Boswell,

717 Myrth Ave. 21221 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Place - American Indian, Black, Whita, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Domino Sugar Co. 11th 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Rufus E. Radcliffe Evelyn Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Marlene Radcliffe / wife 717 Myrth Ave. Baltimore Md 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other p Data 20c. Location - City or Town, Stata 1X Burial 2 Cremation 3 Removal from Stata Oak Lawn Cemetery 12/2/99 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility Connelly Funeral Home of Essex onn 300 Mace Ave. Baltimore Md. 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. trimediata Causa (Final disease or condition resulting in death) Necrotizing Fascitis Myelodysplasia Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequance of): Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

Approximata Interval Between Onset and Death

5 Years

29d. Data signed (Month, Day, Year)

Hours

State Registrar

DHMH 16 Rev 6/95

OSvell, DO

32. Registrar's Signatura

9000 Franklin Square Drive,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

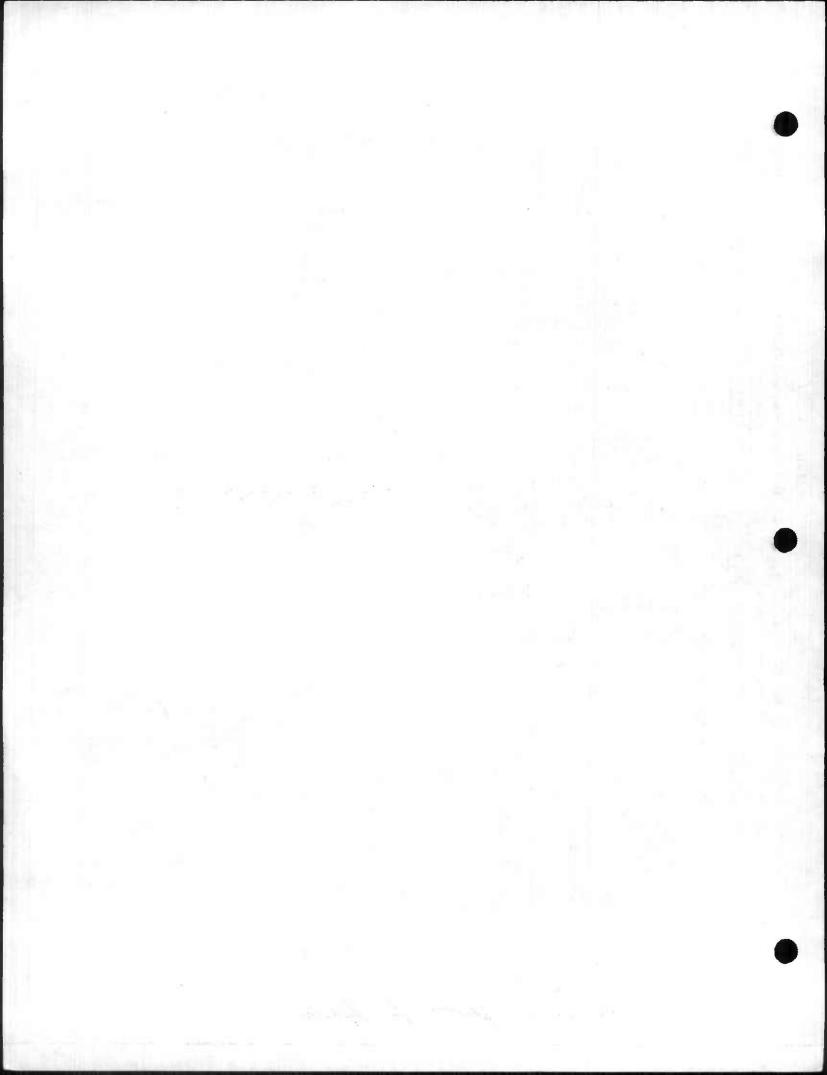
1999

00,

12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

Baltimore, MO 21237



Division of Vital Records.

Physician

· /Medical

Examiner

MD

Director

Funeral

Aq

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examinar must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flee any Injury or other traumatic event.

Physician

/Medical

Examiner

signed by t

funerel director,

Physician/Medical

by

Completed

Be

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Certification:

Medical

29a. Certifier

Baltimore,

nosulgo

Hospital or Attending Physician:
 At hours after death.
 Funeral Director: After this certifical

To the Hosp within 24 hou To the Fune completely fi

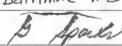
Registrar

KDESAIMO 31. Date filed (Month, Day, Year)

29b. Signatura and title of certifier

4660 Wilkons Are Baltimore MD 21229 32. Registrar's Signature

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)



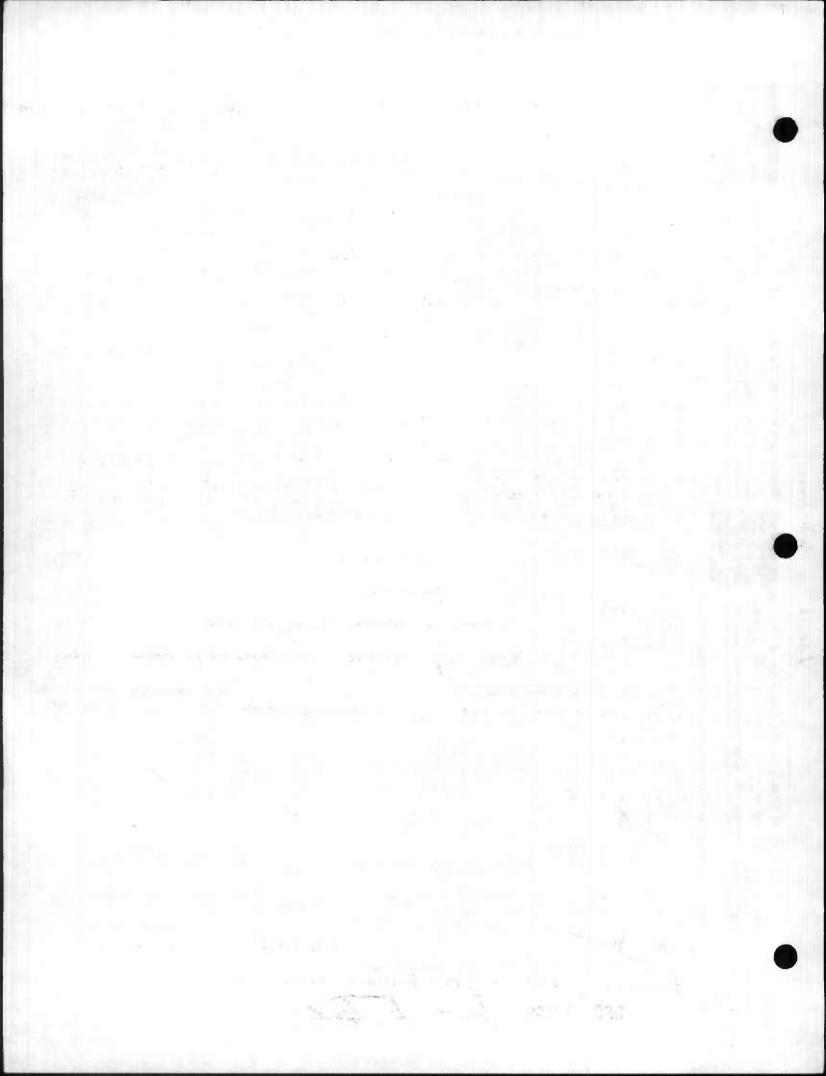
1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

030494

29d. Date signed (Month, Day, Year) 11/30/99



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene QQ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth ROOP **Physician** 2025HRS 25 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE HOSPITAL Hours Min. 8. Date of Birth (Month, Day, NOV 30, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Days Director 212-05-0225 Maryland Usual Residence of Decedent 10a. Siete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Baltimore Catonsville MD 10e. Street end Number 10g. Citizen of What Country? 711 Academy Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours efter to Department of Health end Mental Hygiene. Important: if Item 27 is merked other than "natural", or ther any Injury or other traumatic event. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C&P Telephone 12 Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) George Samuel Espey Margaret Rae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Espey/Nephew 903 Joh Ave., Baltimore, MD 21229 20b. Place of Disposition (Name of commetery, crematory or other place)

Baltimore Nat'l Cemetery 12/2/99 Baltimore, MD 20a. Method of Disposition 20c. Location - City or Town, State N Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

21. Signature of Europea Service Licensed 22. Name and Address of Facility
MacNabb Funeral Home, P.A. 21228 A regorchik 301 Frederick Rd. Balti:

23a. Pert1. Enter the disease, of complications their caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 301 Frederick Rd. Baltimore, MD Approximete Interval Between **Physician** /Medical Immediate Ceuse (Finel INFARCTION MYOCARDIAL disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Lasi Due to (or as a consequence of): Physician/Medical Due to (or as a consequence oi) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HEART FAILURE CONGESTIVE 24b. Were autopsy tindings aveilable prior to completion of ceuse of death? ATRIAL FIBRILLATION Be Completed 24a. Was an autopsy ASPIRATION PNEUMONIA 1 Yes 2 LNO this certificate 25. Was case referred to medical examiner? 26. Piece oi Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 ☐ Homleide To the Hospital within 24 hours a To the Funeral C completely filled 12 Csrtifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end manner es steted.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and dua to the cause(s) and menner stated. 29a, Certifier 29b. Signature and little oi certilier 29c. License number 29d. Date signed (Month, Day, Year) P13601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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of Vital

or Attending Physician: efter death.

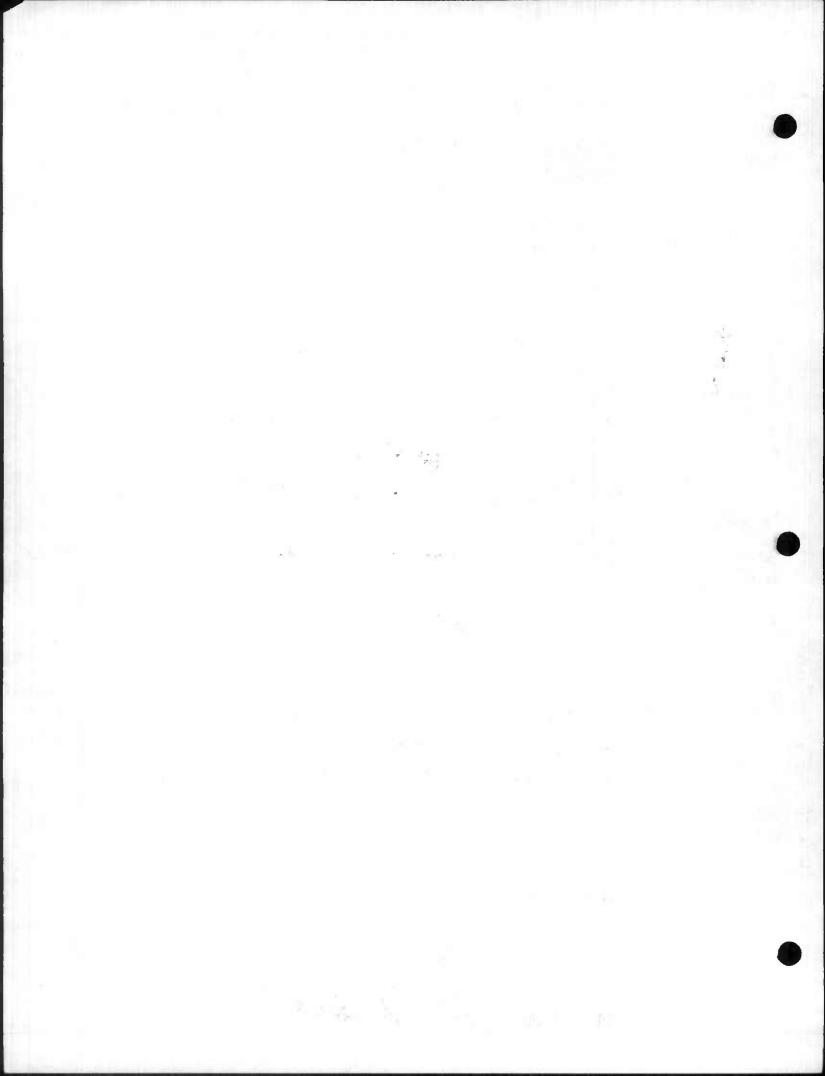
Hospital

Baltimore, Maryland 21215-0020

Registrar DHMH 16 Rav 6/95

31. Dete liled (Month, Day, Year)

DFORI CEASAR; 2506 WEST PATAPSCO AVENUE; APT 3C; BALTIMORE MD 21230 (Month, Day, Year). 32. Registras's Signature south



9000 FRANKlin

32. Registrar's Signatura

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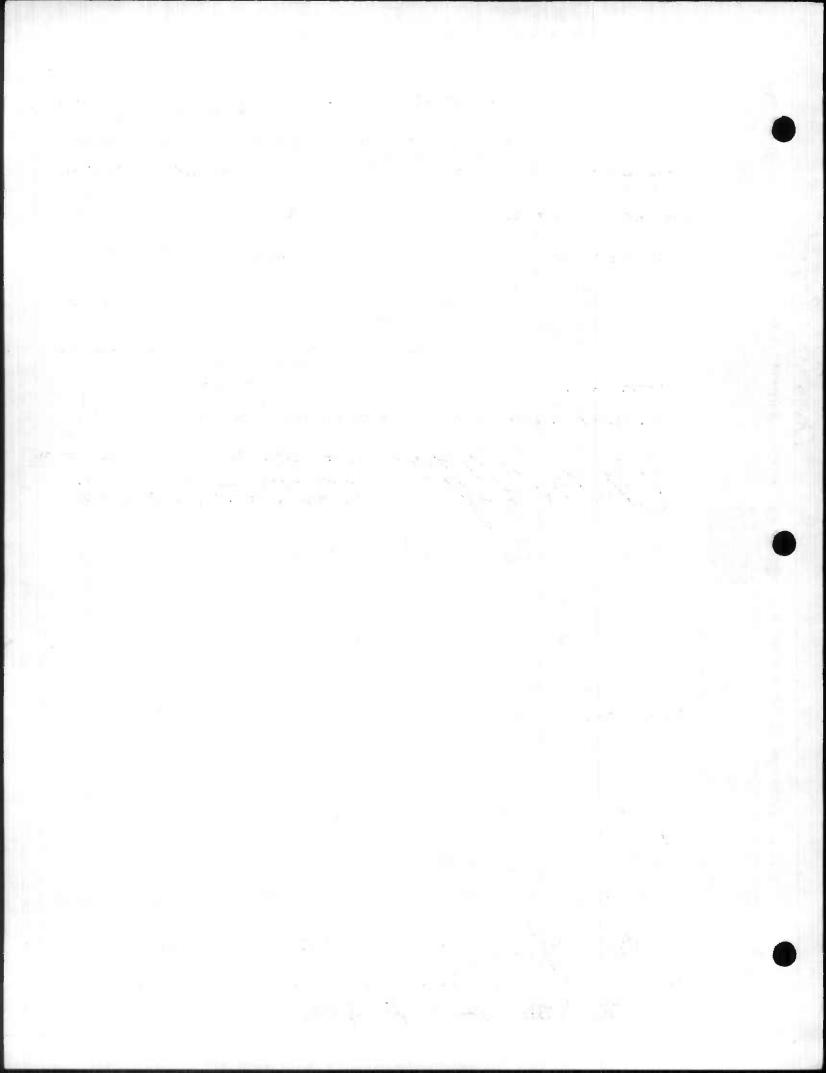
State Registrar DR MARCO ZA

31. Date filed (Month, Day, Year)

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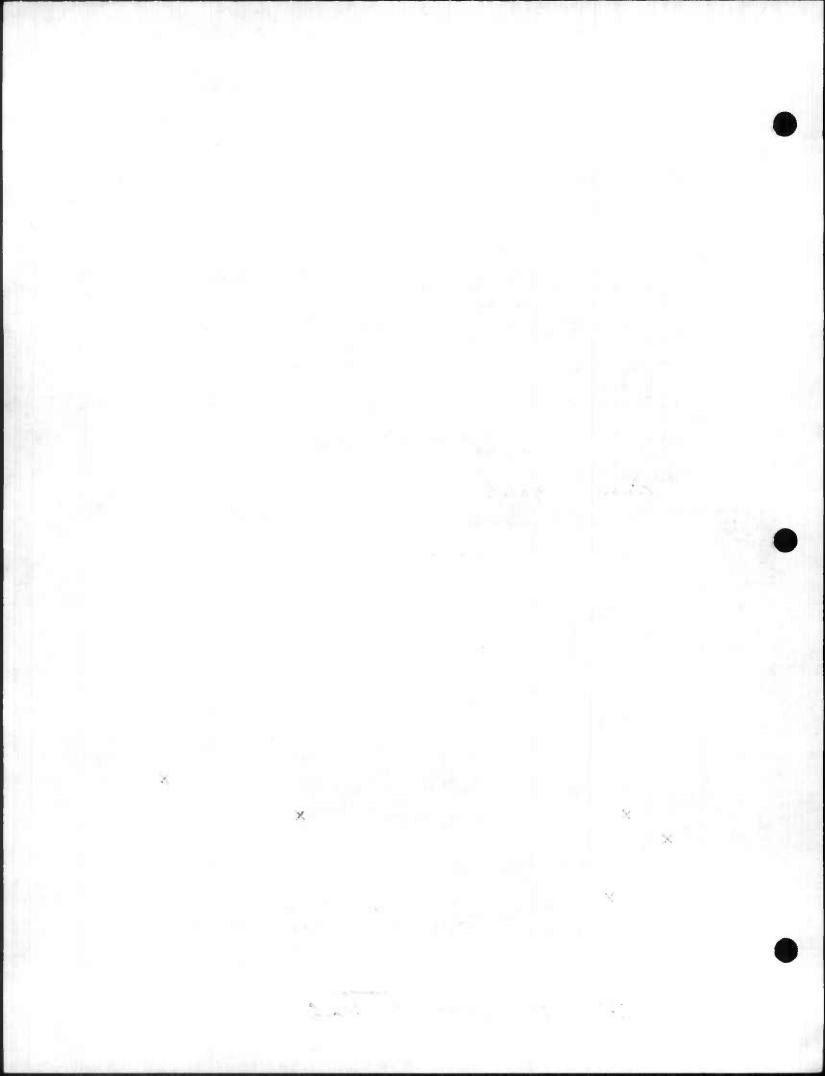


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State of Maryland / Department of Health and Mental Hygiene 99 37838

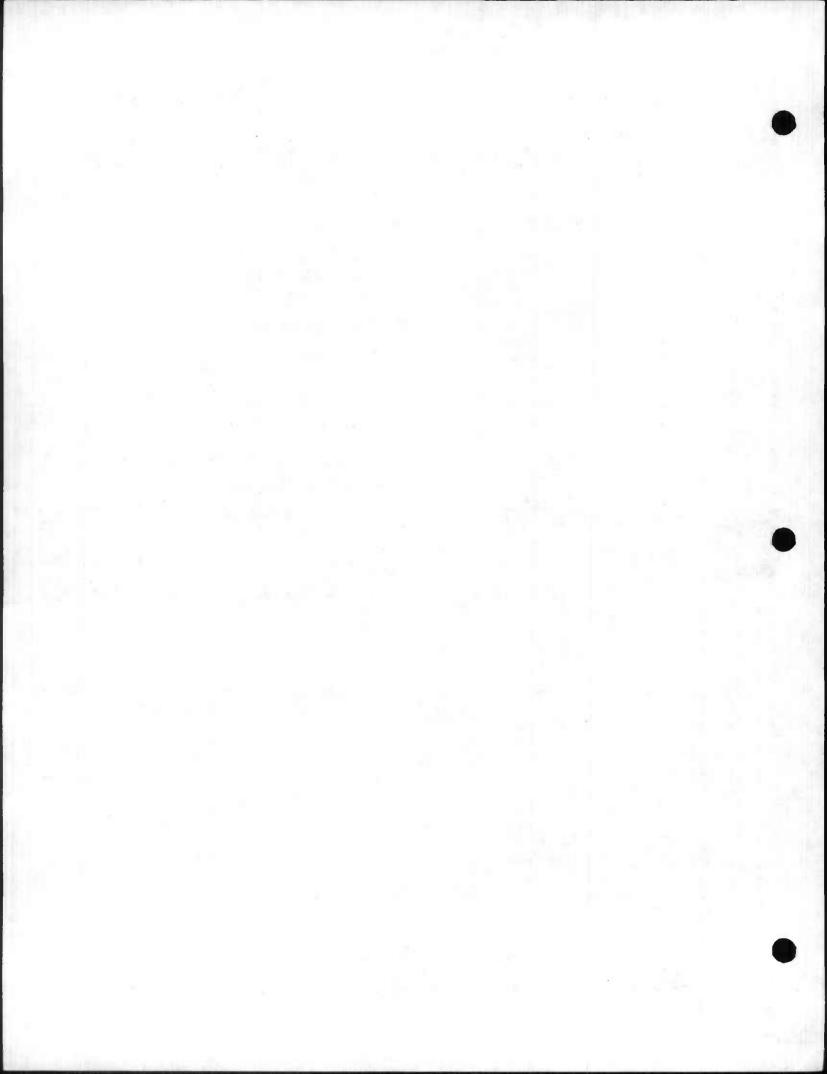
			Cer	tificate of	Death		Reg. No.	1 3/8	38			
Dhuaisia	1. Decedent's Name (First, Middle, Las	,				2. Date of De Month	sath Day	3. Tim	ne of Death			
Physiciar /Medica	NET	son W. Ston	esife	<u> </u>		Novemb	er 30, 1	1999 4	:20 AM			
Examine		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
134	Ridgeway Man			If Under 1 Year	Catons	ville	Ba.	ltimore				
Funeral Director	5. Social Security Number 6. Se 219–12–5943	219-12-5943 1 TM 2 F 73 Yrs. Months Days Hours Min. SEPI 25, 1926 Mary 1 at										
pue &	10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				10d. Insid	de City Limits			
Many	MD Baltim	oro	Cati	onsvill	٥			10	Yes 2 No			
28e	10e. Street and Number	016	Jack	10f. Zip Code			10g. Citizen of \	What Country?	21			
of the death with the Mark ferms 23s or 28sf solos mark be notified	3 Winesap Cour		10 100		.228		USA	American India				
020 us s	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 1 Yes 2 No 19 If Yes, Give Year or Dates: 19	43/1	Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer Specify:	to Rican, etc.)	Specify	ck, White, etc.				
72 h	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occu	pation during most of wo ed)	orking	16b. Kind of Br	usiness/Industry	-1415-1			
1 21215-0 led within 72 ho hygiene. Ner then "neturn nt, me Hedical	Elementary/Secondary (0-12)	College (1-4or 5+)			ed)		Chata	Vocnit	hite dustry pital 21228 own, State , MD Inc.			
tygied y	8 17. Father's Name (First, Middle, Last)		Nur	se	19 Mothor's No	mo /First Middle		-	aı			
Maryland 212: 42 should be filed within th and Mental Hygiene. 71s marked other than treumatic event, tre. H	5	onesifer				azel Un	e, Meiden Sumeme) 1 k .					
aryian should be nd Mental marked o umatic ev	19a. Informant'a Neme/Reletionship (T)		10h Mailin	a Addraga /Chai	t and Number or R			State Zin Code				
M Id 2 Id 2 Id 2 Id 2 Id 2 Id 3 Id 3 Id 3	Erma V. Stonesifer	/wife		nesap (Catonsv			28			
Peges nent of nt: If h	20a. Method of Disposition 1 Burial 2 December 3 4 Donation 5 Other (Specify,	Removal from State	cemetery, crem	sition (Name of natory or other pla ematory,		2/01/99		City or Town, Statemore, M				
Baltim permit. Peg Department Important: I any Injury o ance.	Edward A. Gr	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society Edward A corchik 299 Frederick Rd. 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.										
. Discontates	23e. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea ne cause on eech line.	th. Do not ente	er the mode of dy	ing, such as cardia	c or respiratory a	rrest,	Interval	Between			
Physician (/Medical) Examiner	Immediate Cause (Final disease or condition resulting in death)	Preu	mmi	9				1 64	eck			
<u> </u>		Due to (or as a consequ	uence of):								
58760, icate be executed physician and sthe burial-transit		Due to (or as a consequ	uence of):								
5 0 d	resulting in death) Last	Due to (d	or as a consequ	ience of):								
Seath cert seath cert attendin d for use	Part It Other significant conditions as	nt-ibuting to death but not one	udian in the un	dadina asisa a	inna in Part I	995 Did	tohonon una on	ntribute to the cau	una of death?			
D det the God by the Sotach the S		ntriouting to obath but not rea			3 Probably							
requires should	30					24a. Was	24a. Was en eutopsy performed? 24b. Were autopsy lindings evalleble prior to completion of cause of death?					
1 2 50 5						10	Yes 2 No	1 ☐ Yes	2□ No			
vital The certificate irector, pag	25. Was case referred to medical				26. Place of De	ath (Check only		100				
	1 Yes 2 No	lospital:	ER/Outpatient	3 DOA	hor	Home 5 Resi		er (Specify)				
ing Physical of Uneral of Control		28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ork?		how injury occur					
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, ferm, stre		Yes 2 No		(Street and Numb wn, State)	ber or Rural Route	Number,			
the Hospital bin 24 hours the Funeral upletely filled	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the t estigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) end madate end place,	anner es steted. and due to the ceu	use(s)			
Within Comp	29b. Signature and title of certifier	Taunh			se number			30 - 99	er)			
	30. Nama and address of person who co	Simpleted cause of death (Item		Print)	ND Z	21228	,					
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature &	Kon	Kar			,				

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician /Medical Examiner Funeral	ANNA M. SNYD 4a Facility Name (If not institution, give	EK										
	4n English Name (Mant institution piece					NOV.	T					
Funeral	BLAKEHURST	street and number)			4b. City, Town, or L TOWSON	ocation of Death						
Director	212-07-1372	92 92 Px 3€3xF	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, 9/20/07)	Year) 9	Birthplace (State or Foreign Country) MARYLAND				
show show	Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Lo	cation				10d. Inside City Limits				
the Man 28a-f sh notified rector	MD BALTIM	ORE	TOWSO	N				1 ☐ Yes 2 ☐ XNo				
or 28a-f el be notified Director	10e. Street and Number	· · ·		10f. Zip Code		10	g. Citizen of Wha	at Country?				
23a	1055 W. JOPPA R			21204			USA	A				
natural, or items 23s or 28s-f show older Esseries must be notified at steed by Funeral Director	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	l I	Ves Decedent of H Yes, specify Cubs	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		White, etc.				
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then the	Elementary/Secondary (0-12) 8TH GRADE	College (1-4or 5+)	life. L	O NOT use retired	nost or won		10d. Inside City Limits 1					
d other event.	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	faiden Sumeme)					
To Be	AUGUST BOCK				MINNIE	SAUORSK	Y					
5 5	19a, Informant's Name/Relationship (7					ral Route Number,	City or Town, Sta	ate, Zip Code)				
m 27 her tr	DENISE A. DAMIE			9 THURLO	E DR. TI							
nt: If he ry or of	1X Burial 2 ☐ Cremation 3 ☐ Removel from State											
Department of Health a Important: if Nem 27 is any Injury or other traphose.	TOTTON DARK CONTRACTOR OF THE											
	23a, Party, Enter the disease, or comp	cations that caused the d	leath. Do not ente	8521_LOCI	H RAVEN E	or respiratory erre	WSON, MD					
nysician	23a. Part . Enter the disease, or comp shock, or heart feilure. List only of	one cause on each line.				o. respiretory circ		Intervel Between				
Medical	tmmediate Cause (Final		(V/	7			\sim	1 on KI				
aminer	disease or condition resulting in death) a. Due to (or as a consequence of):											
* 5		(erebro	VASCO	la D	LLAIP		0	year J				
tolen and burtal-transit al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
	Cause (Disease or njury C.											
0.0	resulting in death) Last											
o by the attending stached for use as a Physician/Me												
5 E	Part II. Other significant conditions co	ntributing to death but not	A Torn	idenlying cause giv	en in Part I.							
page 2 should be del	1000	9:00						available prior to completion of cause				
page 2						AFTIN-	a fineti-					
Be Co	25. Was case referred to medical				no Diversit Desi		55.50V2Y00	TLIYes 2LINO				
	examiner?	Hospital: 1 Impatient	2 ☐ ER/Outpation	3EI DOA Oth		th (Check only one	10 Hi A Co. 10	(Cnanki)				
Attac this funeral funeral fon: T	27. Manner of Death 1 Effectual 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injur Wor			and the state of t	oguntary)				
To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spo	t home, farm, streedly)	set, factory, office		28f. Location (Str City or Town		or Rurel Route Number,				
To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only and) 2 Medical Exami	sician: To the best of my liner: On the basis of exam	knowledge, death ination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	end due to the ca red at the time, da	use(s) and mennate end plece, and	er es stated. If due to the cause(s)				
Me Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (/	Month, Day, Year)				
- 0	1	2.		173	2783		BALTIMOR Birth Day, Year) 9. Birthplace (State or Foreign MARYLAND) 10d. Inside City Limits 1					
	30. Name and address of person who o	ompleted cause of death (item 23a) (Type I				V 1					
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9	Joseph Holams	NU 65/02	SNIU	rantes	01-101	Madri	100	11204				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedeni's Nama (First, Middla, Last) 2. Data of Death Day Year TAYLOR KEBA 7:5600 NOVEMBER 28 1999 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE ar | If Under 24 Hrs. CITY 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) NOV.5,1925 9. Birthplace (Stata or Foreign Country) MARYLAND 6. Sax 1 M 2 XF Months Days Hours Min. Yrs. 74 219 10 2447 Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE N/A 1 Yas 2 No 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21212 APT. 102 6225 YORK ROAD U.S. OF A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Manial Status Black, Whita, etc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: BLACK 3 ☐ Widowad 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) STATE OF MARYLAND UNKNOWN CULINARY ARTS UNKNOWN 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) MABLE ARMSTEAD JOHN THOMAS TAYLOR 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) DEISSA COATES (DAUGHTER) ABINGDON, MD. 21009 2961 HARROGATE WAY 20b. Piace of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Buriai 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) LOUDON PARK CEM. 12/3/99 BALTIMORE, MARYLAND 22. Nama and Addrass of Facility LEWIS T. GWYNN FUNERAL HOME 21. Signature of Funaral Service Licens EWAS GWYNN 21215-6393 reform 4517 PARK HEIGHTS AVENUE ewes BALTO., MD. 23a. Part1. Enter the disease, or complications that care ad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause or sold line. Approximata Intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) YEARS Dua to (or as a consequence of). Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequance of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was casa ralarrad to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Yas 25 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data ol Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding invastigation

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

MD.

Funeral

Director

must be notified at

flams 23a or

"natural", or

Hygiene.

permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien (important; if hem 27 is manked other the any Injury or other treasments).

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72 hours after

altimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital I

Director

Funeral

by

Completed

Be

Examiner

physician and the burial-transit Physician/Medical 3 signed t þ Completed Be Certification: To

The law requires that the death certificata be executed i or Attending Physician: after death. Director: After this certifice To the Hospital or Atter within 24 hours after der To the Funeral Directo completely filled in by th

Registrar

DHMH 16 Rev 6/95

edicai

31. Data filed (Month, Day, Year) DEC 03 1999

2 Accident

3 ☐ Suicida

29a. Certifian

4 Homicida

(Check only one)

29b. Signature and title of certifiar

CLU INTERN MD

29c. License number

1 Cortifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year) NOVEMBER 28, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

BALTIMORE, MARYLAND

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) HAGE JOHN

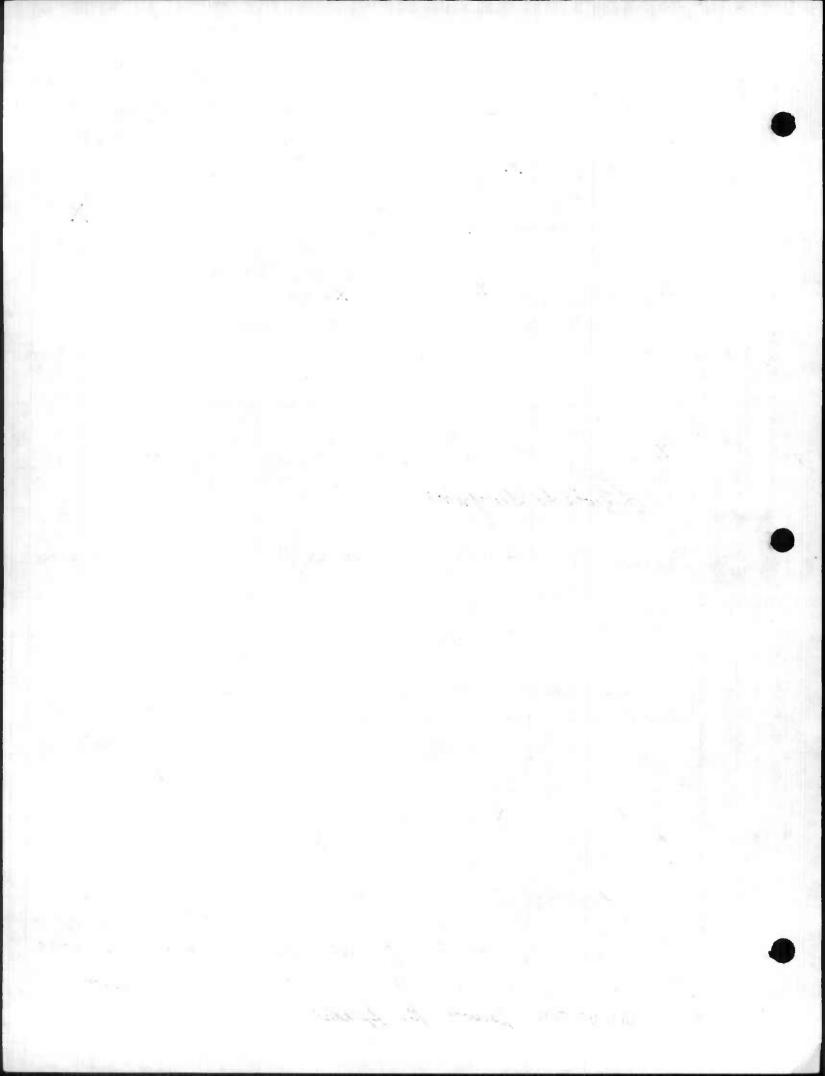
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HOSPITAL JOHNS HOPKINS

32. Registrar's Signatura

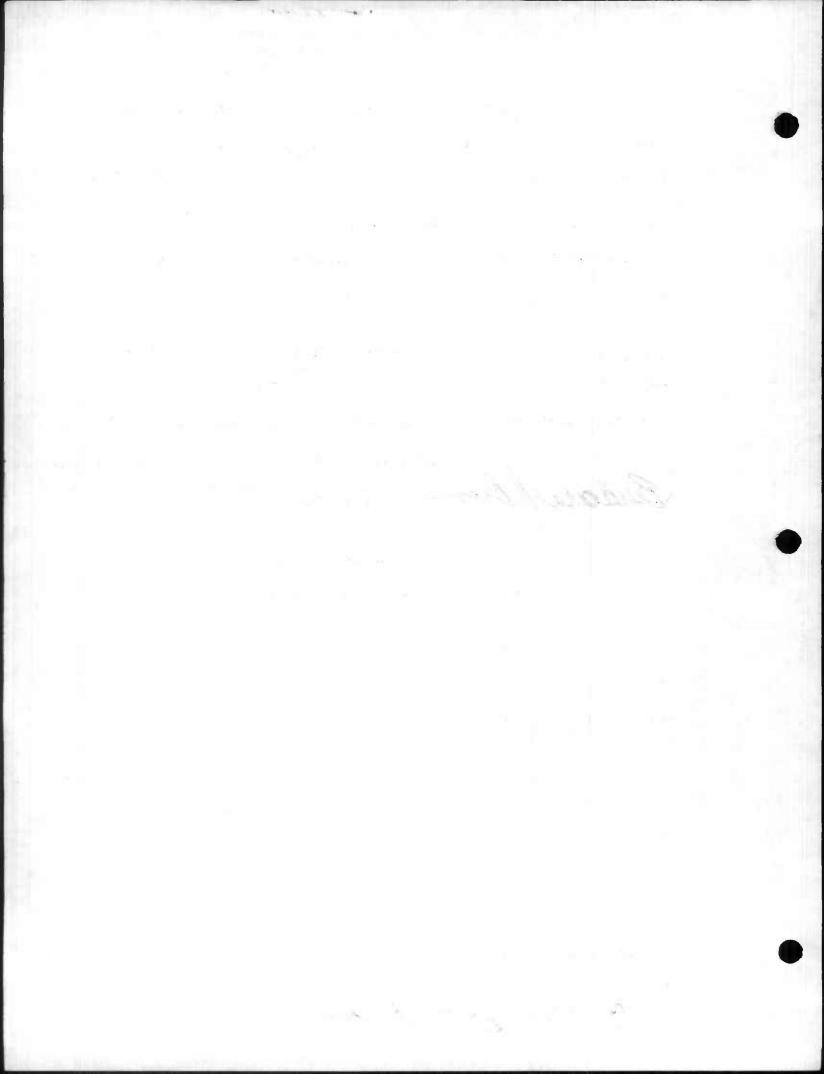
28a. Place of Injury - Al homa, larm, street, lactory, office building, atc. (Specify)

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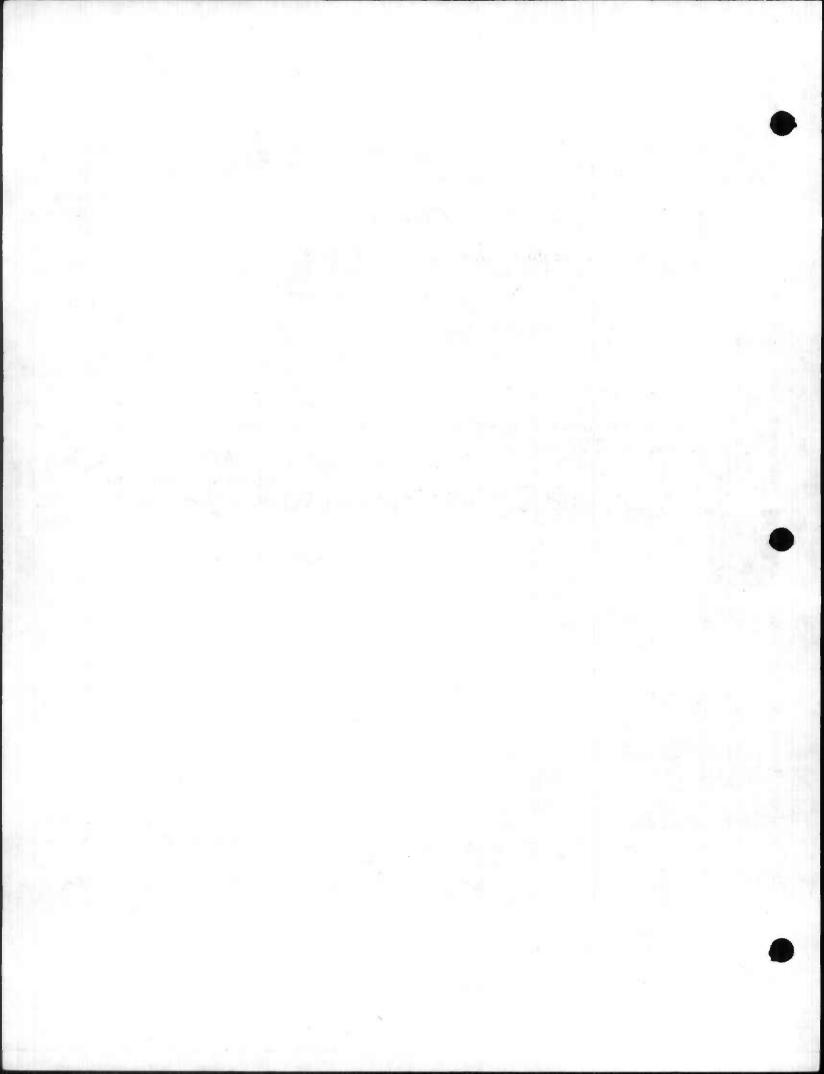


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Exa	amin	er	4a. Facility Name (It not institution 431 TRAVAN)	ORE COL	RT			4b. City, Town, or	Location of Deet	h 4c. County	y of Death	
	-	-	5. Social Sacurity Number	6. Sax	7. Aga (In yrs. le	et hirthday	If Undar 1 Yaar	If Undar 24 Hrs	8. Data of Bir		ct. me.	
Fund Direct			2/3 201096	1□ M 2⁄2 F		86 Yrs.	Months Deys	Hours Min		ly, Yeer)	Country) MARYI	(State or Foreign
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- F	Tiput I	Fun	1 Navar Married 2 Marrie	Armed For	cas?	5. 13. V	Yes, specify Cub	Hispenic Origin? (an, Maxican, Pue	to Rican, atc.)	Bla	ck, Whita, atc.	idien,
72 hours efter natural, or ite	X	þ	3XXWidowad 4 □ Divorced	If Yas, Giv Yaar or Da	а	1	□Yes 2 X XNo	Specify:		Specif	: BLACK	
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	evant, the medical	nple	Elemantary/Sacondary (0-12)	College (1	-4or 5+)	life. L	OO NOT usa ratire	during most of wo	orking			
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nould d Mar	traumenc	2							LA TATE			
J	De L		19a. Informant's Name/Relationship (Type, Print) Joan A. Houston/Niece 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 4317 Travancore Court, Randallstown, MD 21133									
Haelth Heelth	Jeuno		20a. Method of Disposition	- 117 112000	20b. Pla	aca of Dispos	sition (Name of		Data Data		- City or Town,	
Jemit. Pagas 1 er Department of Hae	100	à	1 → Furial 2 □ Cramation ; 4 □ Donation 5 □ Other (Spa	ce)	30/0/00							
permit. Pagas 1 end 2 Department of Haelth s Important: If Item 27 is	a luju	1	21. Signature Funaral Sarvica Li	- 1			A.M.E. C Nama and Addre		12/2/99	COCKEY	SVILLE,	MARYLAN
permit. Departr Imports	SDC SDC		Pruhows	a AR	· com	12	WILLIAM	C BROWN		Y FUNER	AL HOME	PA
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requires that the death cartificate be associated even signed by the attending physician and hould be detached for use on the build be detached.	no eu	Physician/Medical Examiner	Sequantially list conditions, if any, leading to immadiate cause. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Lest	b. — C & C. — d.	Dua to (or	as a consequal	uanca of):	ACL	nent			
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or Attanding Fattar death. Director: Attar		10	1. ■ Natural 5 □ Panding 2 □ Accidant investiga		f Injury n, Day Yaar)	Injury	28c. Inju Wo M 1	rk? Yas 2 □ No	Edd. Daggnibo	non injury coour	100	
Attance ar death ector:	6	Hice	3 Suicida 6 Could no datermin	ad 28a. Place	of Injury - At hon	na, farm, stra	at, factory, office		28f. Location (Street and Num!	ber or Rural Ro	ute Number,
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To the Hospital or Attanc within 24 hours after death To the Funeral Director:	diotoi.	edical Certification:	29a. Cartifiar (Check only one) (Check only one) (Check only one)	Physicien: To tha t caminer: On the ba	sis of examination	ladga, death on and/or inv	occurred at the til estigation, in my c	ma, data and place opinion, death occ	a, and due to the urred at tha tima,	causa(s) and madate and place,	annar as stated and due to the	cause(s)
To th	1		29b. Signatura end titla of certifier				29c. Licans	sa number		29d. Data signe	d (Month, Dey,	Year)
			Clean	1			A 2	-9085		NOU	30 1	999
			30. Nama and address of person wi	no completed cause	of death (Item :	23a) (Type, F		- 1013		,000	20 (179
1 '			Allon J. Ch		531		010 6		000	2	1133	
Pos	State istra	~	31. Data filad (Month, Day, Year)		gistrar's Signatu	ire L	1	61				
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WRC 99-7182-510		Print in Black Indelib			ole.			
UNK. 99-298 JOHN WOOD	State of	Maryland / Departme Certifica	nt of Health and Men Ite of Death	Reg. No.	37842			
Physician	1. Decedent's Name (First, Middle, Last)	2 / -	2. [Date of Death Month Day	3. Time of Death			
/Medical	John Eduard	Wood Sk.		VEMBER 30, 19	999 3:06 PM.			
Examiner	44 Facility Name (If not institution, give street and num 3442 CARDENAS AVE.	iber)	BALTIMOR	,	or Death			
Funeral Director		7. Age (In yrs. last birthday) If Und Yrs. Months	er 1 Year If Under 24 Hrs. 8. C	Date of Birth Month, Day, Year) 12-29-47	9. Birthplace (State or Foreign Country)			
death with the Maryland wre 23e or 28e-f show r must be notified at	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	re	- 44	10d. Inside City Limits 1,			
of the death with the Marking 23a or 284-4 either must be northed the function of the function	10a. Street and Number	1 ,	Tip Code	10g. Citizen of W	hat Country?			
eath w	3442 CARDENAS 11. Meritel Stetus 12. Was Dece		2/2/3 edent of Hispanic Origin? (Specify	Ves or No. 14 Bacs	- American Indian,			
	Armed For 1 Never Married 2 Married 1 Yes If Yes, Giv 3 Widowed 4 Divorced Year or D	ces? If Yes, sp	ecify Cuban, Mexicen, Puerto Rical	n, etc.) Black Specify:	k, White, etc.			
T 9 5 5	15. Decedent's Education (Specify only highest grede completed)	16a. Decedent's Us (Give kind of w life, DO NOT	vork done durina most of workina	16b. Kind of Bu	siness/Industry			
2121 ad within giane. or than ', as then '	Elementary/Secondary (0-12) College/(1		cier	C.N.	F. INC.			
re, Maryland 212 s 1 and 2 should be filed with thealth and Mental Hygiene. then 27 to marked other than other treumatic event, then To Be Comp.	17. Father's Name (First, Middle, Last) JUNUIS WOOD		18. Mother's Name (Fin	Boyce	9)			
Mary 12 sho and M	19a. Informant's Name/Relationship (Type, Print)		ss (Street end Number or Rural Ro	ute Number, City or Town,	State, Zip Code)			
other tr	20a. Method of Disposition	20b. Plece of Disposition (N	ame of De	ate 20c. Location -	City or Town, State			
altimore, mit. Pages 1 a pariment of Hee portant: If Hem y Injury or othe	1 Denation 2 Cremation 3 Removal from 5	Gaccison	Indest V.A. 12.	18/20 Ball:	usce Marulan			
Baltimo pemit. Pages Department of Important: If it any Injury or	21. Signeture of Funeral Service Licensee		end Address of Facility Betts	s fune RAL T	Home			
W 205 4 9	1 alricia	1129	N. Caroline S	+. Baltimore	Md. 21213			
Physician	23a. Part1. Enter the disease, or complications that constructions are shock, or heart failure. List only one cause on enterprise and the shock.	used the death. Do not enter the mo ich line.	ide of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between Onset end Death			
/Medical	Immediate Cause (Final disease or condition	UTING WOUNDS	OKNEUK AND	STABWOUND				
Examiner -	resulting in death)	Due to (or as a consequence of		TO TORSO	1			
scuted ind transit	Sequentially list conditions.	Due to (or as a consequence of	n):					
W W T W	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
587(licate to physics the tables	that initiated events resulting In death) Last	Due to (or as a consequence of):					
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O. B. e deat the att hed for hed for	Part II. Other significant conditions contributing to de	ath but not resulting in the underlying	cause given in Part I.	23b. Did tobacco use con	tribute to the cause of death?			
that the deby the detached detached				1 Yee 2 10	3 Probably 4 Unknown			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be examinin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial Medical Certification: To Be Completed by Physician/Medical Ex				24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
The lar				10 Ves 2 No	tores 2□ No			
Vital clan: clan: entifica ector, I	25. Was case referred to medical examiner?		26. Placa of Death (Ch	neck only one)	AT			
Of \Physic rthis countries of praidire or rthis countries of praidire or rthis countries of rthis countries	XX Yes 2 No Hospital: 1 ☐ II 27. Manner of Death 28a. Date of	patient 2 ER/Outpatient 3 [5 Residence (X)Other	or (Specify)			
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r Atte	3 Suicide 6 Could not be determined 28e. Placa buildin	of Injury - At home, farm, street, factor g, etc. (Specify)	ry, office 28f. I	Location (Street end Number City or Town, State)	rup			
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it completely filled in by the funera Medical Certification:		Dest of my knowledge, death occurre			AUE BRUNUM			
n 24 h		sis of examination and/or investigation						
To the comp	29b. Signature and title of certifier	11 2 2	9c. License number O.C.M.E.	DEC. 01,	(Month, Day, Year) 1999			
6	30 Namerand address of person who completed cause		part Part	M				
State	31. Date filed (Month, Day, Year) 32. Re	-i-td-Oit	ceet, Baltimore,	Maryland 212	301			
Registrar	DEC 0 3 1999	gistrar's Signature	ranks!					



WRC Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 99-7181-510 State of Maryland / Department of Health and Mental Hygiene THOMAS 99 WEBSTER Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 30, 1999 NOVEMBER **Physician** 5:20 PM. Thomas Webster E. Jr. /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 5020 GOODNOW RD. APT.F BALTIMORE Hours Min. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 MM 2□ F Yrs. Director 20 09 215-02-1127 M.D. Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits TY Yes 2 No Director 288-7 MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 860 West Pratt Street 21201 Funeral U.S.A. 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus hours after Never Married 2 Married b 21215-0020 1 Yes 2 No Specify: Specify: ğ 3 Widowed 4 Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Warriors of the Lamb Rapp Group 10th grade Musician Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 89 Pages 1 and 2 should be nent of Health and Mental th and Men 7 is marked traumatic Thomas E. Webster Sr. Pamela Thompson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father Department of Health a important; if item 27 is any injury or other trau 3538 Lyndale Ave, Baltimore Md 21213 Thomas E. Webster Sr. altimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method Disposition Date 20c. Location - City or Town, Stete 1 XBuria 2 Cremetion 3 Removel from Stete 4 ☐ Conet on 5 ☐ Other (Specify) King Memorial Park 12/06/99 Randallstown, 21. Signature d Funeral Service Licen 22. Name end Address of Fecility March F/H West homeson 4300 wabash Ave, Baltimore Md 21215 23a, Part I. Drier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or learn feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Contact Gunshot Wound of Head Examiner or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue Box 68760 Physician/Medical the th Due to (or es e consequence of) P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 3 Probably 4 Unknown 1 Yes 28€No þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? THES 2 No yes 2□ No certificate funarel director, 8 25. Was case referred to medical 26. Place of Deeth (Check only one) XX Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6XOther (Specify) Certification: To this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred SCENE 28b. Time of 28c. Injury at Work? After 5 Pending Investigation Found 1 Neturel 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) self-inflicted gunshot wound after death. 1 Yes 2 No 2 Accident 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 5020 Goal Now Rd 6 Could not be determined 3 Sulcide in by 4 Homictde Baltimore, Mul

Division of Vital Records, To the Hospital or within 24 hours aft To the Funeral Dis completely filled in

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DHMH 16 Rev 6/95

Medical

Dennis 31. Date filed (Month, Dey, Year) State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

3 DEC



111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as steted.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

O.C.M.E.

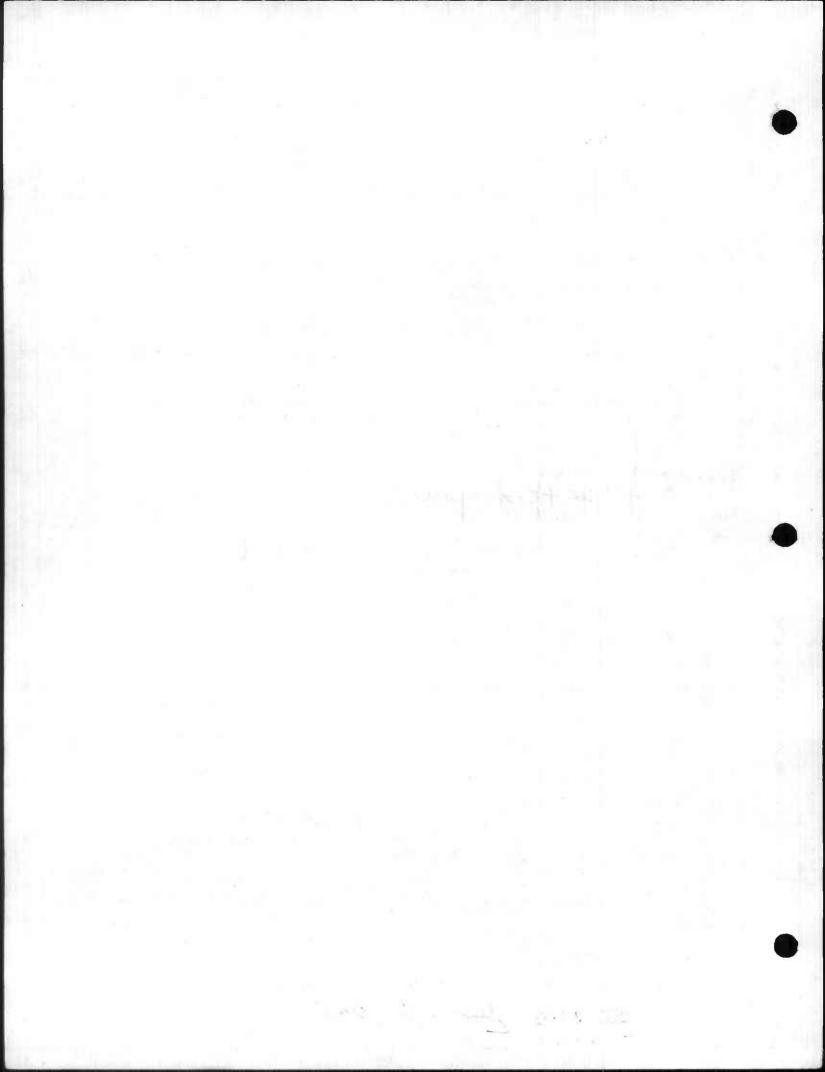
29d. Date signed (Month, Day, Year)

DEC. 01, 1999

4 4 0000

30. Name and address of pusson who completed cause of death (Item 23a) (Type, Print)

home



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Christopher B. Wilson November 30 1999 1458 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner R. Adams Cowley Shock Trauma Center Baltimore If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□ F 20 450-63-5247 Yrs. **Director** April 15,1979 Maryland Usual Residence of Decedent with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yas 2 □ No Directo TN Rhea Dayton 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 478 Horseshoe Circle 37321 USA death , Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. filed within 72 hours after Hygiene. 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student US Naval Academy 2 permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If Item 27 Is marked other eny Injury or other traumatic event, If 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles B. Wilson, Sr. Carolyn McCain 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles B. Wilson, Sr. (Father) 478 Horseshoe Circle, Dayton, TN 37321 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cematery, cremetory or other piece) 1 Durial 2 □ Cremation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) 12/04 Rhea Memorial Gardens Dayton, TN 21. Signature of Euneral Servica Licansaa 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 5 days Massive Infarction Brain Stem, Basilar Ganglion disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last and Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 88 attending Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown Acute Renal Failure þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen Exercise Related Rhabdomyolysis has 1X Yes 2 □ No 1 ☐ Yes 2 No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide 29a. Certifier Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and title of con-29c. License number 29d. Data signed (Month, Day, Year) November 30, 1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) S Greene Street H. Neal Reynolds, R. Adams Cowley Shock Trauma Center, Baltimore, Maryland 32. Regis#ar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene - Q Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 29, Florence Williams Nov. 1:09pm /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Da Manor Care Nursing Home NA 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-28-11 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country)
 M D **Funeral** Days Months Hours 10 M 20 F 88 216-12-8537 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene.

Int: If Itam 27 is marked other than "natural", or items 23s or 28s-f show my: If them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be not feel at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ★SYes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1912 Cecil Avenue 21218 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏃 🗖 No If Yes, Giva Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12th Grade NA Collaga (1-4or 5+) Domestic various trades 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumame) Be George Gaines Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 1025 Punjab Drive Essex, Maryland 20221 Vanda L. Chambers 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crametory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 12-03-99 Arbutus, MD Arbutus Mem. Pk. Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Maryland 21202 ₩M.C.March FH 1101 E.North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not an amount of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed the bunal-tran Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Diseasa or Injury Division of Vital Records, P.O. Box 68760, thet initiated events resulting in death) Last Due to (or es a consequence of): signed by the attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thinknown Puere COPD þ 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy hes this certificate 1 Tyes 2 PNO 1 Tyes 2 TNO ospital or Attanding Physician: Theors after deeth.

Lours after deeth.

Lours Director: After this certificate ity filled in by the funeral director, pa Be 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homloida Mospital 24 hours a Funeral C 29a. Cartifiar (Check only one) 12 Cartifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the causa(s) end mannar as stated.
2 Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, date and placa, and due to the cause(s) and mannar stated. Medical To the Hosp within 24 ho To the Fune completely fi 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D-38754 WVI M.D 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) BASTERN BLVD. MD-21221 MALIKA WASERM 406. 32. Registrar's Signeture 31. Dete filed (Month, Day, Yeer) State DEC 3 1999 Registrar

DHMH 16 Rav 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yee **Physician** 1, Edith December 1999 4:50 a.m. Virginia Williams /Medical 4b. City. Town, or Location of Death 4e Facility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Heart Homes of Piney Orchard Odenton Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpleca (Stete or Foreign Country) Days Hours 1 M 2QF 90 Yrs 212-05-5022 Nov. 1909 Maryland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. tnside City Limits 1 TYes 2 No Directo Odenton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8735 Piney Orchard Parkway 21113 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Maker 12 Own Home 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be George Washington Buckman Florence Rhodes 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1727 Tipton Drive Mrs. Bette W. Lewis/Daughter Crofton, Maryland 21114 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removal from State Donetion 5 Other (Specify) Thomas Episcopal Cem. 12/4/99 Owings Mill, Maryland 21. Signature of Peneral SetVice Licensee 22. Name and Address of Fecility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a, Pert1. Entar tha dispase, or complication the caushock, or haart failura. List only one causin according caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Interval Batween Onset and Deeth Immediata Cause (Finel reumonio diseese or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last previscu acciden Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ρ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Be Completed completion of cause of death? tailure 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA LIVI-27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred Residen Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 ☐ Suicide 4 T Homicide

that the death certificate be executed Box 68760 P.O. Records, Division of Vital Attending ŏ **Funeral**

Director

tem 27 is marked other than "natural", or hema 23a or 28a-f show other traumatic event, the Hedical Examinar must be notified at

hours after

e filed within 7; al Hygiene. I other than "n.

permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If flem 27 is marked other by Injury or other traumatic event ance.

Physician /Medical

Examiner

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signed by the a

this

After

within 24 hours after death To the Funeral Director: , completely filled in by the

To the within 2

death.

Baltimore, Maryland 21215-0020

28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledga, daeth occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier

12-1-99

30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print) 479 Hon MID

Severna Park My Tumpers

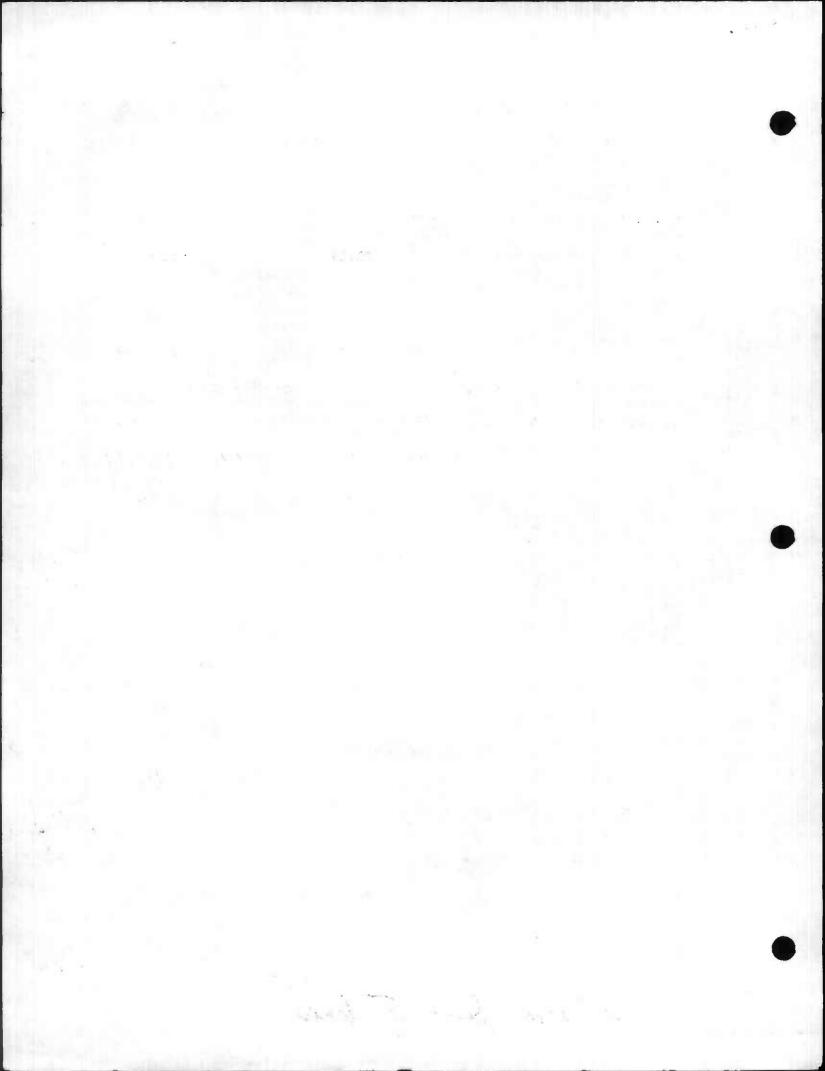
State Registrar

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31. Data filed (Month, Day, Year)

32. Registra Signature

DHMH 16 Ray 6/95



Months

7. Age (In yrs. last birthday)

Yrs.

State of Maryland / Department of Health and Mental Hygiene 'Q Q Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Daath 3. Time of Death

If Undar 1 Yaar | If Undar 24 Hrs.

Hours

Deys

29c. Licansa number

D48152

1221 Mercantile Lane, Upper Marlboro, Md. 20774

Month

4b. City, Town, or Location of Death

Bethesda

November

8. Date of Birth (Month, Dey, Yeer)

15,1999

4c. County of Daeth

Montgomery

9:15 P.M.

Physician

/Medical

Examiner

Funeral

Clara Mae Tate Allen

4e. Fecility Name (If not institution, giva street end number)

1□M 2\ F

Suburban Hospital

5. Social Security Number

242-64-6218

Usuel Residence of Decedent

10e State 10b. County 10c. City, Town or Location D.C. N/A Washington Director 10e. Street end Numbe 10f. Zip Code 4300 Ord St., N.E. 20019 Funerai 11. Marital Status 12. Was Decedent Ever In U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 Never Married 24 Married 1 □ Yas 2 X No 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Teacher 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumeme) Melvin Tate Clara Scott 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) James L. Allen/Husband Same as # 10 above 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Data 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State Chesapeake Crematory, Incl1/17/99 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funarai Servica Licensee 22. Name and Address of Fecility
H.S. Washington & Sons Co., Inc. Ba Depa Many i 4925 Burroughs Ave., N.E., Wash., D.C. 20019 ratt 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heer failure. List only one ceuse on each line. **Physician** /Medicai Immediate Cause (Final diseesa or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner bone descer The law requires that the death certificate be executed burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of) P.O. Box 68760. physician Cancel Physician/Medicai the for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. deteched signed by Hy po thyroidum à 8 Completed peen this certificate hes 1 Tyes director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1☐ Yes 2☑ No 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be 3 D Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide

40

Registrar's Signetura

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Samuel Semegn, M.D.

NOV 1 8 1999

9. Birthplece (Steta or Foreign Country) N. Carolina 5/4/40 10d. Inside City Limits 1X Yes 2 □ No 10g. Citizen of Whet Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Education 20c. Location - City or Town, Stete Beltsville, Md. Approximate Intervel Between Onset end Deeth 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an eutopsy performed? 24b. Wera autopsy findings availabla prior fo completion of cause of deeth? 2 1 No 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end menner steted. 29d. Dete signed (Month, Dey, Year) November 16,1999

Division of Vital Records, Attanding Physician: To the Hospital or Attanding Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

> State Registrar

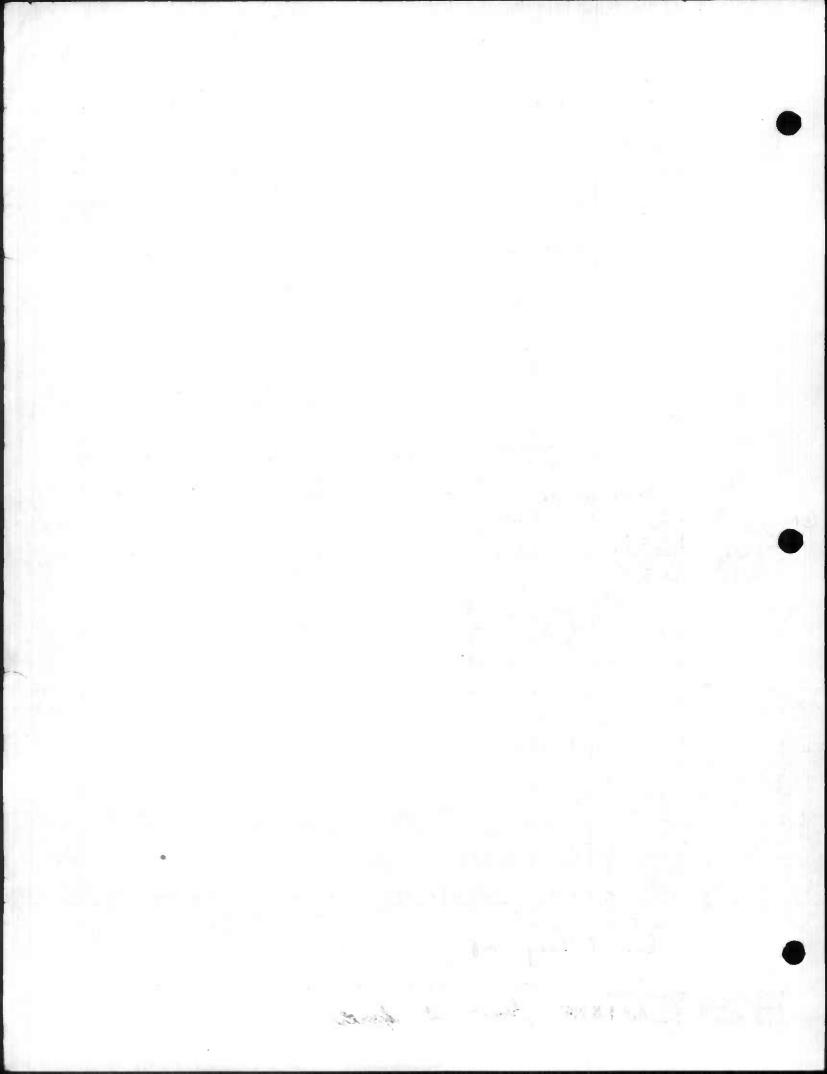
29e. Certifier

(Check only one)

29b. Signeture and fitte of certifier

31. Date filed (Month, Day, Year)

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	/Medi	cal	Carlyle F. A 4a. Fecility Nama (If not institution, giv.		-1			4b. City, Town, or L	Novembe:		999	3:45 PM.
7	Examir	er	Washington Adve		,			Takoma P		4c. County of Death Montgomery		CV CV
I	Funeral Director		5. Social Sacurity Number 6. S 440-30-6213	ax 7.4	Aga (In yrs. last bi	rthday) If Undar Yrs. Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey, July 6,			laca (Stata or Foreign
-	and	ctor	Usual Rasidance of Dacadant 10a. Stata 10b. County		10c. City, Toy	vn or Location					1	Od. Insida City Limits
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020	iten Iten	Be Completed by Funeral	11. Marital Status 1 Navar Married	12. Was Dacadar Armed Forcas 1 ☑ Yas 2 ☐ If Yes, Giva	s?	13. Was Deced		Ilspanic Origin? (S) en, Maxican, Puart Spacify:	oecity Yas or No- o Rican, etc.)		a - Americ ck, Whita,	
2-00	"natura		15. Decedant's Ed	lucation		Decedant's Usua	al Occup	pation		16b. Kind of Br		
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Mary	1 end 2 should be filed within Health and Mental Hygiene. Health and marked other than other traumatic event, traum	Ţ	19a. Informant's Name/Ralationship (Mary Jo Alexande					and Number or Ru irch La.				Code)
Baltimore, Maryland 21215-0020	Papes 1 end nent of Health nt; if Nem 27 ry or other tr		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		camata	of Disposition (Nan ary, crematory or o and Veten	thar ple		Data 11/18	20c. Location -		
alti	permit. Pa Departmen Proportant: any injury otice.		21. Signature of unaral Sarvice Licen		S V W	22. Name en			Takoma 1			
-	Ill.	5	tangel 8	Bil	and			11 St. N	W. Washi	ngton,		
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	Physician /Medical Examiner		Immediata Causa (Final disaasa or condition	· SEP:	515							
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P.O.	het the de od by the detached								1 Yes 2 No 3 Probably 4 Unknown			
Division of Vital Records,	The law requires thet the death certificate has been signed by the attending page 2 should be detached for use es	Completed by							24a. Was a	n autopsy med?	evi	are eutopsy findings ailable prior to appletion of causa
Rec	The law ate hes b page 2 s	mpi								as 2 No	of	deeth?
tal		BeC	25. Was casa referred to madical					26. Placa of Daa	th (Check only on		1	Yes 2 No
> t	hysici this ce al direc	To	axaminar? 1 ☐ Yes 2 X No	Hospital: 1 Inpa	tiant 2 ER/O	utpatient 3 DC	Oth Oth	nar: 4□ Nursing H	oma 5 🗆 Rasida	anca 6 🗆 Oth	er (Specif	v)
sion o	ading Physician: ath. After this certifican to funeral director,	Certification:	27. Mannar of Death 1 Natural 5 Pending invastigation		ojury 28b. Day Year)	Tima of 2 Injury M	8c. Injui Woi 1 □	ryet rk? Yas 2□No	28d. Dascribe ho	ow injury occur	red	
Divis	(1)		3 ☐ Suicida 4 ☐ Homicide 6 ☐ Could not be datarmined 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)						28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)			
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	To the To the comple	×	29b. Signature and title of certifler	Jan 1	land			se number		9d. Data signe		
	(2)		30. Name and andress of person who	completed cause of	death (Item 23e)	(Type, Print)	050	761		JUUCH	1961	14, 1999 D. 20705
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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician Month Year 11/12/99 4:15 PM ODA EMILIE ANDREE /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Yrs. Director 073-03-9427 95 July 6, 1904 New York Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Yes 2 No Directo Maryland | Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Items 23a 9708 Narragansett Parkway 20740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No if Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, The Medical Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 6 1 Yes 2 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White 'naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clothing Worker Bond Clothing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be nent of Health and Mental William DeCaire Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health and: If Item 27 is m Robert A. Leverance - Son 9708 Narragansett Parkway, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 11/16/99 Manasota Memorial Park Bradenton, Florida 71. Signature of Figural Service Licensee 22. Name end Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 Demot enter the mode of dying, such as cardiac or respiratory arrest, er complications that caused the do ist only one cause on each line. Approximate Interval Between Interval Between Onset and Death Physician /Medical Immediate Cause (Final herry in disease or condition resulting in death) **Examiner** Due to (or as a consequenca of) Examiner sician and burial-trensit The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequenca of): P.O. Box 68760. physician is the buria Physician/Medical Due to (or es e consequence of): 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s certificate has been signed director, page 2 should be de Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes No certificate 1 Tyes 2 □ No of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide in by t 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the 29a, Certifier Medical (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature 29c, License number 29d. Date signed (Month, Day, Year) 2261 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) TOUS AMEADRIC Ld, LOWLAN NO 20706 Feldnan my

State Registrar

31. Date filed (Month, Day, Year) NOV 1 6 1999

3. Registrar's Signature

Carolina Committee Committ

the Comment of the Co

Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Myron 3:50 (N ASh November 199 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore nue Maryland 17 if Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 120 M 2□ F Yrs. Director 46 9/10/53 228-76-9075 Virginia Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1√2 Yes 2 No Director Maryland Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21236 deeth 66 Park Hill Place U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status permit. Peges 1 end 2 should be filed within 72 hours effer of Department of Heelih and Mentel Hyglene. Important: if Item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Examinat Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: Afro American 3 ☐ Widowed 4 Ø Divorced Afro American Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) welder iron works 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Ashe Helen Johnson Ashe 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Partricia Ashe Crabbe(sister) 1906 High Timbers Fort Washington MD. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 11/13/99Hague VA. Zion Baptist Church 4 Donetion 5 Other (Specify) Berry O. Waddy 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 305 a 6784 Mary Ball Road Lancaster Virginia 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or healt feiture. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immediate Ceuse Final disease or condition resulting in deeth) /Medical rial mening, tis Examiner Examiner attending physician and for use as the burial-transit certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? The law page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28h Time of 26a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 1 Netural 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e, Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

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State

Registrar

Adavn 31. Dete filed (Month, Day, Year)

NOV 1 5 1999

32. Registrar's Signature

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Registrar's Signature

South

Grene St. Baltimore

1. 1999 January 668: 5 1. 160

State of Maryland / Department of Health and Mental Hygiene

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	Physic	ian	Decedent's Neme (First, Middle	, Lest)					2. Date of Dee Month	Day Ye	3. Time of Deeth
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И	LXaiiii	ici	Washington Adve	ntist Hosni	tal			Takoma I	Park	Montgo	
Г	Funeral		5. Sociel Security Number	6. Sex 7. A	ge (In yrs. last b	irthday) If Un Montl	der 1 Year	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day)		Birthplece (Stete or Foreign
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	show	٦	10e. Stete 10b. County			wn or Location					10d. inside City Limits 1 X Yes 2 □ No
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Maryland	should be nd Mental merked o	To Be	George Otis	Buckholtz				Bertha	Elizabe	th Finl	ev
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	and 2 salth a n 27 is		Helen L. Buckho	ltz - Wife	t .	5902 31	st Av	enue, #21	6, Hyatt	sville,	MD 20782
Baltimore,	permit. Pagas 1 and 2 she Department of Health and Important: If Itam 27 is me any Injury or other treums once.		20e. Method of Disposition	0	20b. Plece	of Disposition (/	Vem e of	·	- T	20c. Location - City	
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alt	permit. Pa Departmen Important: any Injury once.		21. Signeture of Funerel Service I	icensee	^	22. Name	end Addre	ss of Fecility			•
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	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	e. CH @		BIFLU consequence		LUN	6)1	16A16	10 7620)
oʻ	death certificate be axecuted e attending physician and of for use as the bunal-transit	Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury								
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	daath cer e attendir d for use	lcia	Pert II. Other significent conditio	as contributing to death h	out not resulting	In the underlyin	a ceuse air	en in Part I	23h Did to	hacco use contrib	ute to the cause of death?
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of <	\$ 00	To	examiner? 1 Yes 2 No	Hospitel: 1 Inpati	ent 2 ER/O	utpetient 3	DOA Oth	er: 4 Nursing H	ome 5 Reside	nce 6 Other (S	Specify)
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1	0) 1Va		30. Name end address of person v	the completed cause of c	deeth (Item 23e)	(Type, Print)	R	CUDEL: PE	B.A. +	Leadui	15, 1999 16 MD 2078.
	Sta	ite	31. Dete filed (Month, Day, Year)		rer's Signeture	4	,			17-11-11	7 2 10

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Tima of Death **Physician** November 16, 1999 6:15 A.M. Ola Catherine Bridgett /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner Prince George's Co. 6121 Auth Road Camp Springs If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthpleca (Stete or Foreign Country) **Funeral** 1□ M 2XX Months Days Hours Yrs. Director 579-14-8827B 81 Sept. 11, 1918 Ohio Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Prince George's Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20746 6121 Auth Road U.S.A. Peges 1 and 2 should be filed within 72 hours after death nent of Heelth and Mentel Hygiene.
Instit if lean 27 la marked other than "natural", or theme 23, mix if it lean or the traumatic event, in Medical Exertine multipy or other traumatic event, in Medical Exertine multiple. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc. 1 ☐ Yes ZONo If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White by 3 ☐ Widowad 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greds completed) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) College (1-4or 5+) 12th N/A Homemaker Home 18. Mothar's Name (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middla, Last) Be Risden Stewart Asbury Harriet Edna Vaughn 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Woodrow Louis Bridgett (Husband) 6121 Auth Road Camp Springs, Maryland 20746 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) Nov. 22,1999 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) permit. Pege Depertment of Important: If any Injury or once. Maryland State Veterans Cem. Cheltenham, Maryland 22. Name end Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Pert . Enter the disaese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximata Intervel Between Onset and Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Coronary artery disease Due to (or es e consequence of): Deripheral Vascular desease Examiner Examiner 'eripheral physician end s the buriel-transit Sequentielly list conditions, if erry, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated avents resulting in deeth) Lest Due to (or es a consequence of) Box 68760. Hypertension certificate be Physician/Medical Due to (or es e consequenca of): 88 use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2 No Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 s certificate has 1 Yes 2 No 1 Yes 2 No N/A Division of Vital or Attanding Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 Sich funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Neturel 2 Accident after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by Hospital 24 hours a Certifying Phyafclan: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to tha cause(s) and mannar statad. 29e. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of aeryl 29c. License number 29d. Date signed (Month, Dey, Year) D0052999 11/17/99 Tahumidu MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10 7801 Old Branch Avenue #409 Clinton, Maryland A. Rahimian MD 31. Dete filed (Month, Dey, Year) 32_Registrer's Signeture NOV 1 3 1999 b. food Registrar

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MON 1 2 1833

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 2. Date of Death Day Betty Bickerton November 1:03 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Regional Prince George's Hospital Laurel Laurel If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yaer) If Under 1 Yaar 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 1□M 2XF Months Days 579-52-9712 March 31, 1940 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inaide City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7810 Clark Road, #A10 20794 U.S.A. 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Resident Manager Apartment Buildings 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Joseph D. Henry E. Childress Mary 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debra L. Bickerton - Daughter 1025 Cattle Land, Lusby, Maryland 20657 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from Stata 11/22/99 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility 21/Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 4739 Baltimore Avenue, 20781 ROW Part1. Enter the disease, of complications that coused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death ACUTE RESPIRATORY FALIURE Immediate Cause (Finel disease or condition resulting in death) A CUTE BRONCHITIS Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, laading to immadiate ceuse. Enter Underlying Cause (Disaase or injury that initiated avents resulting in death) Last CHRONIC OBSTRUCTIVE PULMONAY DISEASE 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of ceuse of death? 1 Yas 2 10 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel axaminer? 1 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 2 any highry or other traumatic svent, the Mexical Examinet must be an once.

Baltimore, Maryland 21215-0020

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Directo

Funeral

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Physician/Medical Examiner ettending physician end for use as the burial-trensit þ Completed Be 2

Certification:

Medical

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Division of Vital Records, P. or Attending F 124 hours after to Funeral Directions of Funeral Directions of the Funeral Directions of the Funeral Property of the Funeral P Hospital

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31. Dete tiled (Month, Dey, Year) State

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signatura and titla of certifier

28a. Date of Injury (Month, Dey Year)

29c. License number

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

28c. Injury et Work?

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) ARKWAY GREEN BELT MD 20770

32, Registrer's Signeture

NOV 1 9 1999

5 Pending

Investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Registrar

power D. frake

8981 € 1 VON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Day **Physician** Morris William Benthall November 11, 1999 2:40 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Yaar If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Deys 1 M 2 F Months 578-52-1991 60 July 23, 1939 Washington, Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City. Town or Location x 28a-f show a notified at 10d. Inside City Limits 1 Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Harne 23a or 901 New Jersey Avenue, NW, #712 20001 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian 11. Marital Status Bleck, White, atc. 72 hours after 1 ☐ Yas 2 ☒ No If Yes, Giva Year or Datas: 1 Never Married 2 Merried "natural", or Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Asfault Labor Government permit. Pages 1 and 2 should be fliad will Department of Health and Mental Hygion Important: If Item 27 is marked other the any injury or other traumatic event. Its 9th 17. Father's Nama (First Middle Last) 18. Mothar's Name (First, Middle, Maiden Sumema) 89 William Benthall Florence Owens 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 901 New Jersey Avenue, NW #712, Washington, DC 20001 of Disposition (Nama of Data 20c. Location - City or Town, Stata Juanita E. Benthall/Wife 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removel from Steta Harmony 11/18/99 Landover, Maryland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Johnson & Jenkins Funeral Home 20 luo 716 Kennedy St., NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician /Medical Immediata Causa (Final disease or condition resulting in death) Pneumonia days Examiner Due to (or as a consequence of) Examiner Debilitation due to stroke and Metastatic prostate years physician and the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): cancer Box 68760. edical Due to (or es e consequence of). Physician/M 188 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown Š 24b. Wara autopsy findings evailable prior to completion of causa of death? 24e. Was an eutopsy performed? Completed hes 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2€ No 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury et Work? After 1 Natural 5 ☐ Pending n 24 hours effer death.

Ne Funerei Diractor: Afte bietely filled in by the fur 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and mannar stated. 29a. Certifie edical (Check only one) To the F 29b. Signeture and titla of countries 29c. License number 29d. Data signed (Month, Day, Year) D34590 No November 11, 1999 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) 20910

Registrar

31. Duta filed (Month, Day, Year)

NOV 1 6 1999

32. Registrer's Signature

Roy Fried MD, Kaixr Office, Holy Cross Hospital, 1500 Forest Glen Rd., Silver Spring

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Velva Headley November 12, 1999 4:47 pm /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days 85 Yrs. Director 579-16-1128 May 14, 1914 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7905 25th Avenue 20783 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. al Hygiene. 1 Never Married 2 N Married Specify: White 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 end 2 should be file ment of Heelth end Mental Hy lant: if itam 27 is marked oth jury or other treumatic event Syrus Keyser Sebra Mary 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Theodore P. Belt - Husband 7905 25th Avenue, Adelphi, Maryland 20783 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11/16/99 Brentwood, Maryland Signature of Funeral Service Lifety 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Part I Enter the disease a standard shock, or heart failute. List only plications that caused the one cause on each line Onset and Death **Physician** /Medical Immediate Ceuse (Final MASSIVE UPPER GASTROINTESTINAL BLEEDING disease or condition resulting In deeth) Examiner Due to (or es e consequence of): 7 AND SEPSIS Examiner physician and the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medicai Due to (or as a consequence of): 98 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d 1 Yes 2 No 3 Probably 4 Unknown DAYPOVOLEMICAND SEPTICSHOCK DDIABETES MELLITUS by BCORDHARY ARTERY DISEASE (4) DUODENAL EROSION 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of deeth? 5 RESPIRATORY FAILUE 6 HYPERTENSION O ACIDOSK 1 Yes 2 No 1 ☐ Yes 2 ☐ No END STAG 25. Was case referred to medical examiner? END STAGE RENALDISENSE DENTEROCOLITIS Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 1 Matural 5 Pending To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fune 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier Mohammed A. Mannan D24593 3331-TOLEDO TERRACE, HYATTSVILLE, MD. 20782 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) . D.) 31. Date filed (Month, Day, Year) Registrar's Signeture State NOV 1 6 1999

Registrar

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Baltimore, Maryland 21215-0020

Box 68760

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State of Maryland / Department of Health and Mental Hygiene 37856 Certificate of Death 1. Decedent's Nama (First, Middia, Last) 3. Time of Death 2. Data of Death **Physician** November 1999 7:30PM Patricia Ann Brown /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6 Say 8. Deta of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1 M 2 TF 316-46-0840 55 Yrs. **Director** Aug. 18, 1944 Indiana Usual Rasidanca of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or frama 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ♥ Yas 2 No Maryland Directo Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 206 College Station Drive 20774 United States death Funeral 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast greda completed) Data Processing permit. Pages 1 and 2 should be filed within: Department of Health end Montal Hygiene Important: if Item 27 is marked other than "n any Injury or other traumatic event College (1-4or 5+) Elamentary/Secondary (0-12) Private Supervisor 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middla, Last) Be Lucy Mae Owens Louis Nathaniel Batson 2 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 206 College Station Dr., Upper Marlboro, MD 20774 Arthur A. Brown - Husband 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Date 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata Lee's Crematory Clinton, MD 4 ☐ Donation 5 ☐ Othar (Specify) 11/18/99 21. Signatura of Funaral Sarvice Licensage 22. Name and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 woul enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediata Cause (Final disaasa or condition rasulting In deeth) /Medical Examiner Examiner Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Box 68760. Physician/Medical Dua to (or as a consequence of) the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? No 5 3 Probably 4 Unknown signed b Records, by 24b. Ware autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 10 2 NO 1 Yas Division of Vital or Attending Physician: 25. Was cesa rafarred to medical 26. Place of Deeth (Check only one) Hospitel: Nunpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 27. Menner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 Pending Invastigation 1 Matural within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be datarminad 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida Hospital Medicai 29a. Cartifiar Certifying Physician: To tha best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 29c. Licanse number 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) 00 Fros () filed (Month, Day, Year) 32. Registrer's Signatura State Registrar NOV 1 6 1999

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State Registrar 31. Dete filed (Month, Dey, Year)

NOV 1 6 1999

29b. Signeture end title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DO

South

Baha Momeni, M.D., 301 Hospital Drive, Glen Burnie, Maryland 21061

29c. License number

H0053939

29d. Dete signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** 99 11 12 9:00 am /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) 9. Birthplece (State or Foreign **Funeral** 1 □ M 2 X F Months Days 237-72-1916 Yrs 51 September 14,1948 North Carolina Director Usual Residence of Decedent with the Meryland 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits show tem 27 is marked other than "naturel", or hams 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at Maryland Prince George's Yes 2 No Ft. Washington Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6721 Botetourt Drive 20744 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours efter deeth v Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or thems 23s any injury or other traumetic event, the Medical Examples install Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11 Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Private Accountant 12th 18. Mother's Name (First, Middle, Melden Sumeme) 17. Father's Neme (First, Middle, Last) Be Arthur Williams Willie B. Green 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Cain E. Brimage/Husband 6721 Botetourt Drive, Ft. Washington, Maryland 20744 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 11/17 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Harmony Memorial Park Landover, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 1999 21. Signature of Funeral Service Licensee J.B. JENKINS FUNERAL HOME Percen 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the minute, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. List only one ceuse on each line. Physician /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner physician end the burief-trensit thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest PLQ Division of Vital Records, P.O. Box 68760, nuelon Physician/Medicai Due to (or as a consequence of) 88 esn Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? ed by the deteched 1 Yes 2 No 3 Probably 4 Unknown signed l by 24b. Were autopsy findings eveileble prior to completion of cause Completed 24e. Was en eutopsy of deeth? page 2 s 1 ☐ Yes 2 No 2 No certificate 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZN No 2 1. Inpatient 2 ER/Outpatient 3 DOA this funerai 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of After 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No Investigetion 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, Ierm, street, fectory, offica building, etc. (Specify) 4 Homicide filled in 24 hours Hospital rs Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated. 29e. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d, Date signed (Month, Dev. Year) nessa 10 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 900 Swan Creek Road East, Ft. Washington, Maryland 20744-5250 Vanessa Allen, M.D. 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Registrar NOV 1 6 1999

Marine V. Land

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State of Maryland / Department of Health and Mental Hygiene 37859 Certificate of Death 1. Decedent's Neme (First Middle Lest) 2. Dete of Deeth Dey **Physician** Month Veer MRS. FERN V. BELT 11 - 09- 1999 9:25a.m. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** SACRED HEART HOME, INC. HYATTSVILLE PRINCE GEORGES If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
JAN. 23,1906 7. Age (In yrs. lest birthday) If Under 1 Year 5. Sociel Security Number 9. Birthplace (State or Foreign **Funeral** Deys 1□M 2□ F 93 Yrs. 579-01-4542 Director MARYLAND Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ne 23a or 28a-f shov 1 Yes No Director VIRGINIA FATRFAX ANNANDALE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4327 RAVENSWORTH ROAD, #221 22003 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. treumatic event, the Medical Examiner 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specity only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiane. Elementery/Secondery (0-12) College (1-4or 5+) SECRETARY WESTINGHOUSE 12 other pemit. Pages 1 and 2 should be file Department of Health and Mantel Hy, Important: if Itam 27 is marked other any injury or other treumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be ANTHONY CZYZ VERONICA LAMECKA 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) LINDA LEE-DAUGHTER 4327 RAVENSWORTHROAD, #921, ANNANDALE, VA. 22003 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 11/12/99 BALTIMORE, MARYLAND HOLY ROSARY CEMETERY 4 ☐ Donetion _5 ☐ Other (Specify) 21. Signature XEMAINE FUNETRAL HOME RINGFIELD Pert1. Enter the chease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, a hear majore. List only one cause on each line. Intervel Between Onset end Deeth **Physician** Myocardal Infarction /Medical Immediete Ceuse (Finel disease or condition resulting in death) Examiner The Breats with petastaris Years I or Attending Physician: The law requires that the deeth certificate be associated after death.

Director: After this cartificate has been signed by the attending physician and in by the luneation of the page 2 should be deteched for use as the burnar-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Box 68760, Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 1 ☐ Yes 2 No Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours a 24 hours a Funeral L complataly filled McCartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end menner steted. 29a. Certifier Medicai (Check only one) To the I within 2 29b. Signeture end title of cartifier 29d. Dete signed (Month, Dey, Year) 37934 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 7500 Green belt Road Green belt MD 20770 Stephanie Trifogli. MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State NOV 1 5 1999 Registrar

DHMH 16 Ray 6/95

END IT	1.	xter 23a, per i IS: #@# PART I Decedent's Neme (First, Middle, L	est)) Cért	tificate o	f Děath``	2. Dete of De Month	eath Dev	9 3 7 0 0 3. fine of 0 Year 1999 8:15 A
/Medical	4.	Loretta Patri a Facility Neme (If not institution, gi					4b. City, Town, or	Novem		
Examiner		5804 Annapolis			t 1001		Bladensb			ce George's
Funeral Director	5		Sex 7.	Age (In yrs	. last birthday) Yrs.	Months Dey			rth ay, Year) -72	9. Birthplace (State or Country) Maryland
a or 28a-f show be notified at	. [0a. State 10b. County		10c. C	ity, Town or Loc	ation				10d, Inside City
t or 28s-f sho be notified at Director	1		George'	s B	ladens			1		1 DXYes
Di Di		0a. Street and Number 5804 Annapolis	Road A	Apt.	1001	10f. Zip Code 2071			10g. Citizen of V	
r Itama 23a iloer.must Funeral	11	1. Maritel Stetus	12. Was Deced	ent Ever in U			f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No	U.S.	ce - American Indian,
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feerta feed fe e		James Baxter S	Sr.				Mary	Bates		
and is me	15	9a. Informent's Name/Relationship	(Type, Print)		19b. Meiling	Address (Stre	et and Number or R	ural Route Numb	er, City or Town,	Stete, Zip Code)
nent of Health and Murt. If Ilem 27 is mer	M.	ary Bates-Sist Da. Method of Disposition 1 Guarial 2 Cremation 3 E 4 Donetion 5 Sother (Speci	Removal from St	ale	1275 Place of Dispos cemetery, creme rest H	ition (Name of etory or other p	Pl. Apt	.#4 Wa 99 11-30	20c. Location -	City or Town, Stete
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Dunn & Sons Funera. 5635 Eads St., N.E. N.

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Day Month Milton Eugene Bailey, Sr. November 6, 1999 7:45 a.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Elder Care La Plata Charles 8. Date of Birth (Month, Day, Year) July 23,1947 5 Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours Min 1 ■ M 2 □ F 213-44-4419 52 Yrs. Virginia Usual Rasidence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ■ No St. Mary's Maryland Great Mills 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 22048 Baja Lane 20634 United States 12. Was Decedent Ever in U,S. Amed Forces? 1 ■ Yes 2 □ No It Yes, Give Year or Datas: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ■ No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Care Taker State College 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Norman Edward Bailey Irene Beatrice Keeling 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Karen Miller, Daughter 5112 Merlin Court, Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Ramoval from State Maryland Veterans Cemetery 11-12-99 Cheltenham Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility eral Edicolistansee Brinsfield Funeral Home, P.A. Michael K. Blankenship, M00857 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one causa on each lina. Approximate Interval Batween Onset and Death Immediate Cause (Final X MONTH disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yee 2 No 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed?

Physician /Medical Examiner

certificate be exec

livision of Vital Records, P.O. Box 68760

liny

Attending

8

after death Director:

24 hours Funeral

To the Within 2 To the

Department of Important: If is any Injury or o

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

"natural", or items 23s or noticel Examiner must be r

Pages 1 and 2 should be filed within 72 hours after death neat of Health and Mentel Hygiene.
In: If them 27 Is marked other than "natural", or items 23 mry or other traumatic event, an Wedien Event or many or other traumatic event, and we get the structure from the present of the structure of t

Maryland 21215-0020

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Funeral

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Examine and physician a Physician/Medical 2 2 detached signed by to ģ Completed page 2 certificate 89 2 8 Certification:

Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona) Other: Other Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - Af home, farm, streef, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

25. Was cese referred to medical examiner? 1 Yes 27. Manner of Death 1 Natural ident

5 Pending Investigation

6 Could not be determined

29a. Certifier (Check only anel

3 Sulcide

4 - Homicida

ortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. idical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and magnet signal.

29b. Signatury and title of certifie

License number

29d. Date signed (Month, Day, Year)

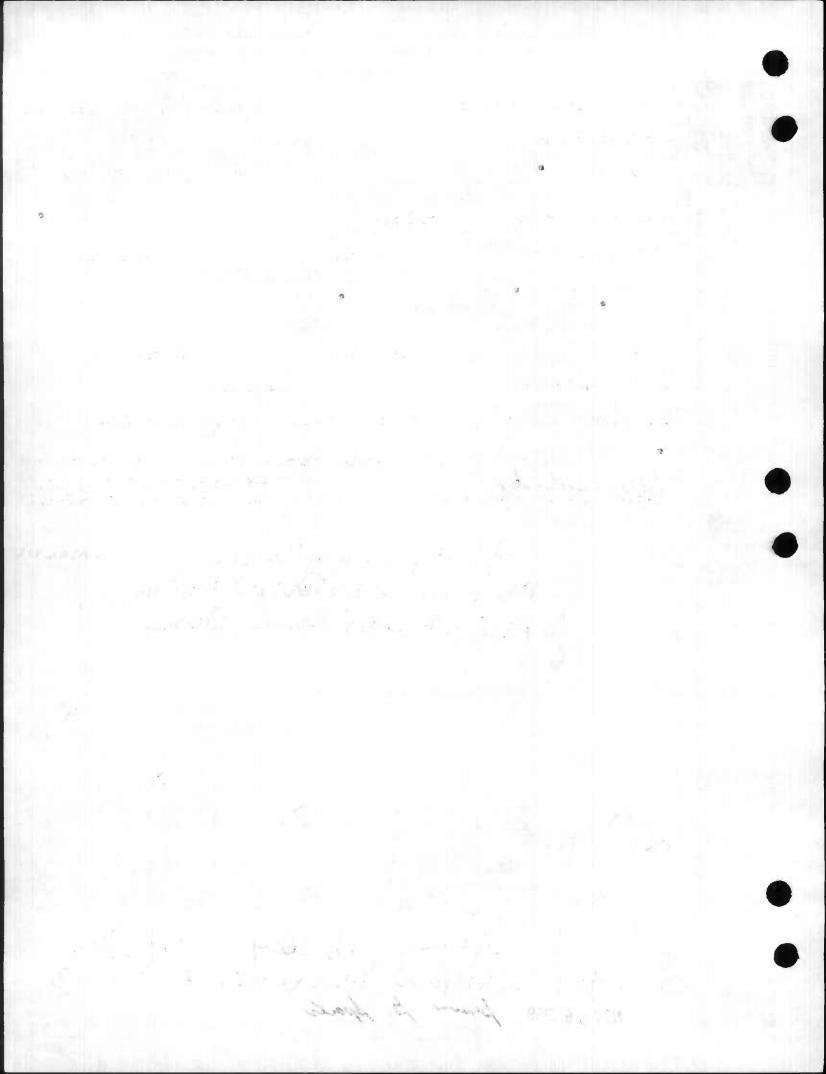
person who comple ed causa of death (Itam 23a) (Type, Print) 30. ATHEN

31. Dala filed (Month, Pay, Year) NOV 09 1999

32. Registrar's Signature

State Registrar

Medical



State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time f the **Physician** NOVEMBER Day 1999ar Grace Beitzell 08:27 AM /Medical 4e. Facility Nama (If not institution, giva straat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 6. Sax 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** 1□M 20 F Days Hours 80 579-46-7676 Yrs. Director January 11, 1919 Maryland Usual Rasidenca of Decedant the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show ns 23a or 28a-f sh Maryland St. Mary's Leonardtown 14 Yas 2 □ No Director 10a. Street end Number 10f. Zip Code 10g. Citizan of What Country? death with 20650 Cedar Lane Court U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ဩ No If Yas, Giva Year or Detes: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Merital Status 14. Rece - Amarican Indian, traumatic event, the Medical Examiner Bleck, White, atc. filed within 72 hours efter 1 Nevar Married 2 Married 21215-0020 6 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced "naturaf", White Completed 15. Decedent's Education (Specify only highest greda complated) Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Hygiene. Elemantery/Secondary (0-12) Collega (1-4or 5+) 12th Homemaker Own Home other Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) . Peges 1 and 2 should be file ment of Health and Mental Hy lant: If Item 27 is marked oth jury or other traumetic even Mary Ida Cheseldine Charles Henry Beitzell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 23409 Colton Point Road, Clements, Maryland 20624 Alice B. McWilliams / Sister 20a. Mathod of Disposition 20b. Piaca of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State 1X Burial 2 □ Cramation 3 □ Ramovel from Stata permit. Pege Department of Important: If any injury or once. 11/10/99 Bushwood, Maryland Sacred Heart Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licansa 22. Nama and Addrass of Fecility Mattingley-Gardiner Funeral Home, P.A. 23a. Part 1. Enter tha disaasa, or complications that caused the death shock, or haart failura. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Do not entar the moda of dying, such as cerdiac or raspiratory errast, Approximata Intarval Between Onsat and Death **Physician** /Medical Immediate Causa (Final disaasa or condition rasulting in deeth) Examiner Fram Stem The law requires that the death certificate be executed burial-transit Sequantially list conditions, if any, leeding to immadiate ceusa. Entar Undarlying Causa (Disaasa or Injury that Initiated evants rasulting In daeth) Last Box 68760, atueros decony + de Physician/Medical the for use signed by the all be deteched for P.O. Part II. Other significant conditions contributing to death but not rasulting in the undarlying ceusa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was cesa referred to medicel axaminar?
1 ☐ Yas 2 ☑ No 26. Piece of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To of this 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury et Work? 28b. Time of 5 Pending investigation Division 1 Natural within 24 hours after death. To the Funeral Director: A 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) filled In by 4 Homloida Hospitai 29a. Certifiar 1 🔀 Cartifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) and mannar as statad. Medical completely 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 01380 ess of person who completed cause of death (Item 23e) (Type, Print) 30. Name and add Leonardtown, Maryland 20650 F. FENWICK M.D. 31. Data filed (Month, Dey, Year) JOHN

32. Registrar's Signatura

1999

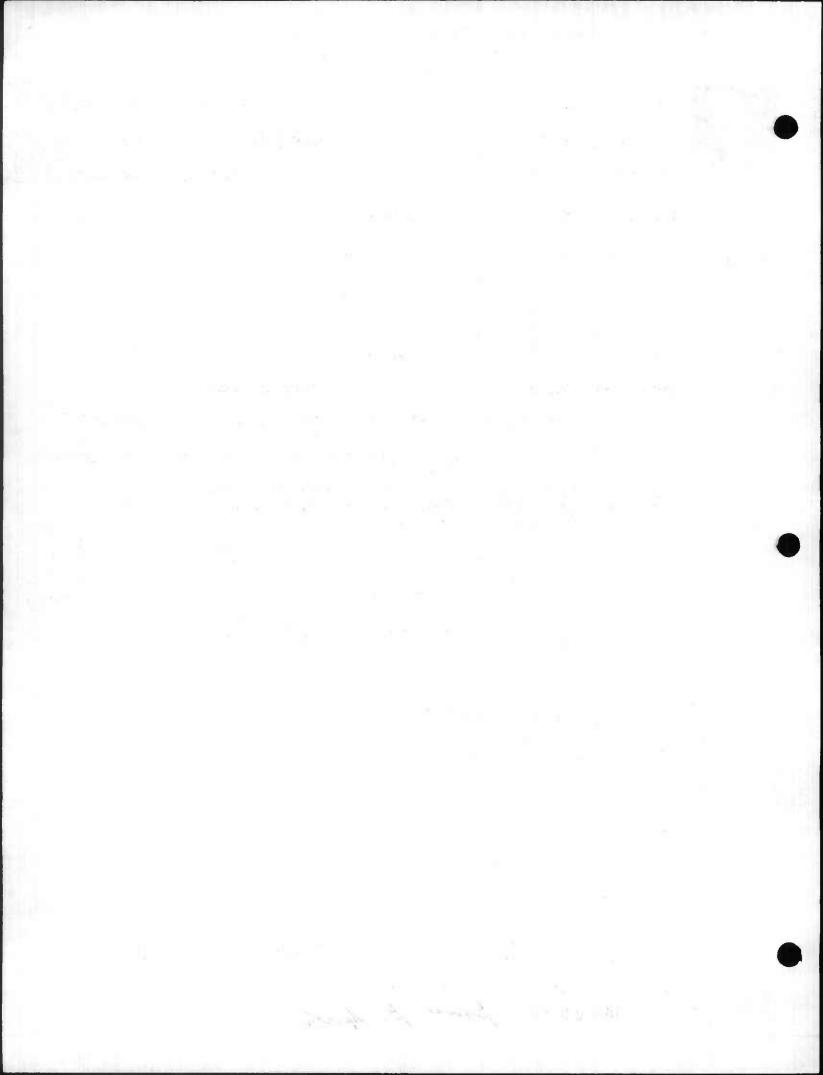
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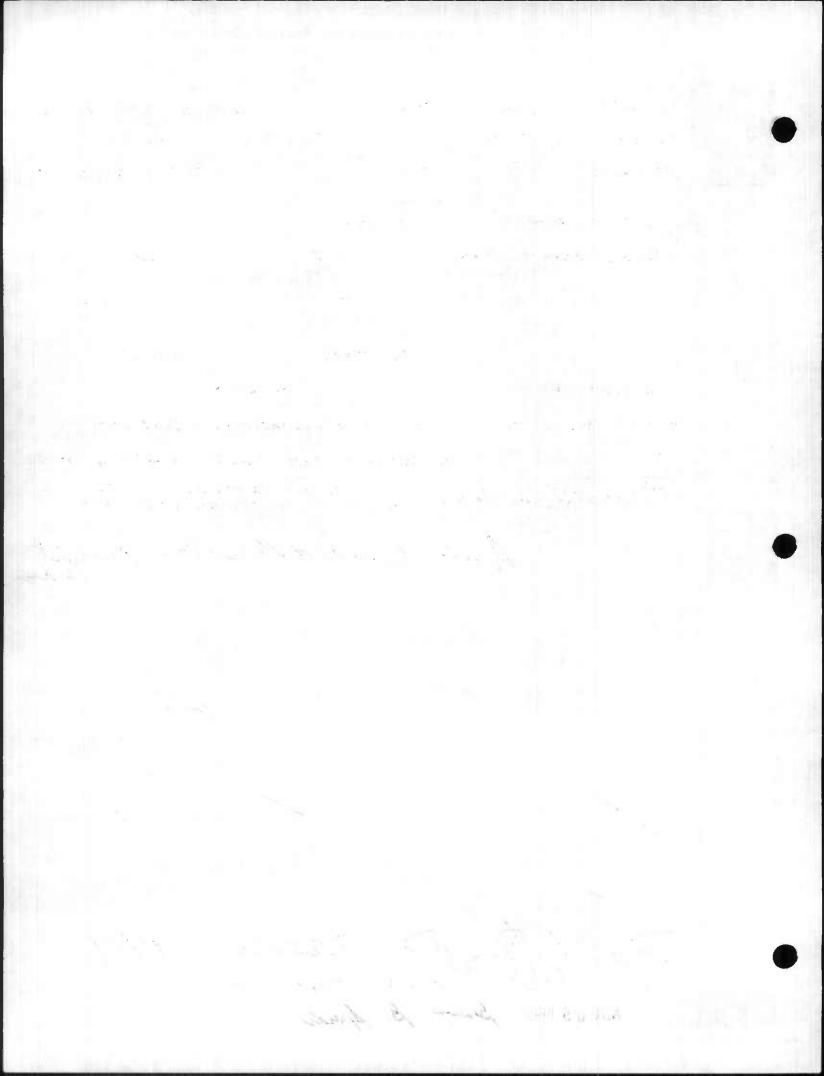
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Catherine Bennett November 6, 1999 Marie 2:20 AM /Medical 4h. City. Town, or Location of Death 4c. County of Death 4e Facility Nema (If not institution, give street end number) Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Undar 1 Year | If Undar 24 Hrs. Birthplece (State or Foreign Country) 8. Data of Birth (Month, Dey, Year) August 31, 1913 5. Sociei Sacurity Numbar 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours 10M 20F 218-24-0591 86 Yrs. Director Maryland Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stete show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42274 St. Andrews Church Road 20650 U.S.A. Funeral death 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yas 2X No If Yes, Give Yaar or Detas: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0020 λq 3X Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highast grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 8th Ward Clerk Hospital 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic svent pine. 17. Fether's Neme (First, Middle, Last) Alexander Wilkerson May Jarboe 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Thomas R. Bennett/ Son P.O. Box 261, Leonardtown, Maryland 20650 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 11/8/99 St. Aloysius Cemetery Leonardtown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

11. Inter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest,

Approximately a superior of the control of the contr Approximete Intervel Between Onset and Deeth **Physician** reloro Vascular Acc Immediate Cause (Finel disaase or condition resulting in deeth) /Medical **Examiner** Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events the attending physician and hed for use as the burial-tran Due to (or es a consequence of): that the death certificate be axec Box 68760. Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 8 24b. Were eutopsy findings available prior to 24e. Was en eutopsy performed? Completed completion of cause of deeth? paga 2 certificate has 1 Yes 2 No 1 Yas 2 No 25. Wes cese referred medical axaminer? Be 26. Piece of beeth (Check only one) Hospital: Other: 4 Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient To 2 ER/Outpatient 3 DOA After this Dete of injury (Month, Day Yaar) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Certification: or Attending 5 Pending investigation 1 Neturel s after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) In by 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 \ Homicide Hospital 24 hours t Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as steted. edical 29e. Certifier completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end manner steted. (Check only one) within 2 4 29d. Date signed (Month, Day, Year) 29c. License number cause of deeth (item 23e) (Type, Print) David C. Allen Leonardtown, Maryland 20650 31. Date filed (Month, Dey, Year) 32. Registrer's Signature NOV 0 9 1999 Registrar

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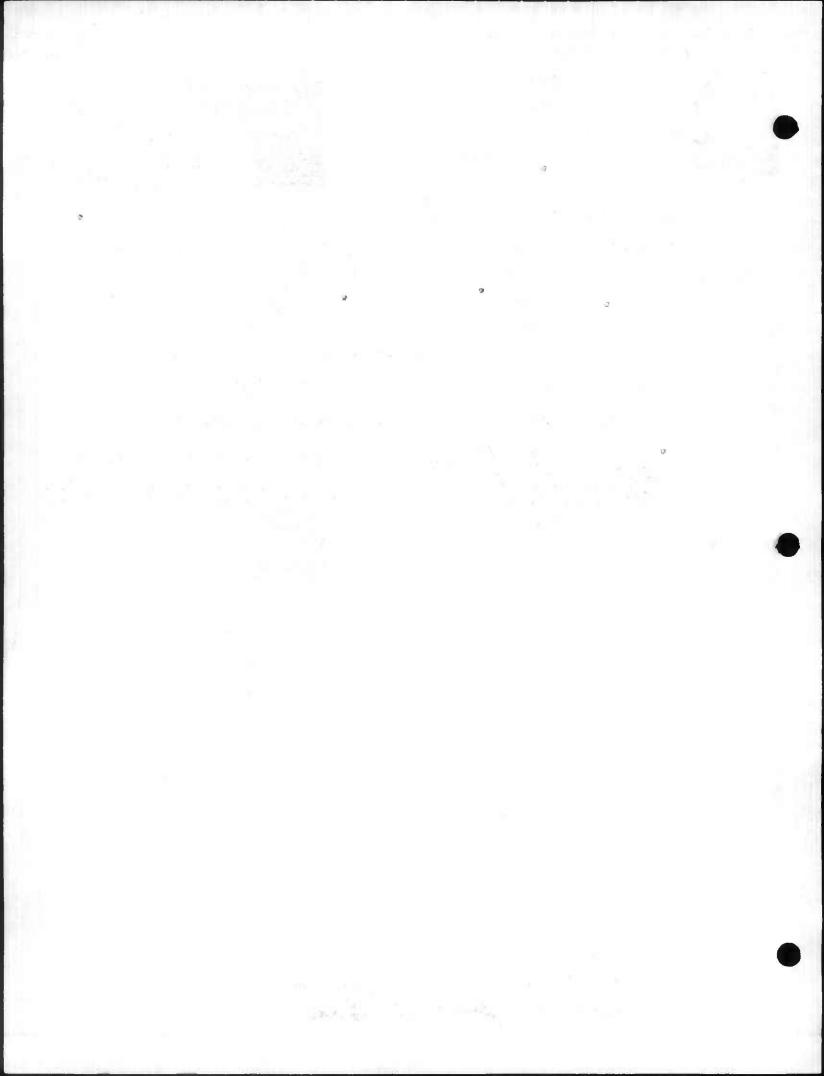
BOSLEY

ARTHUR

JOHN

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** NOVEMBER 20, 1999 John Arthur Bosley 3:55AM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Days | Hours | Min. | October 26, 1911 5. Social Security Number 216–10–7490 7. Age (In yrs. lest birthday) 88 Yrs. Birthplace (State or Foreign Country) Funeral 1 ■ M 2 □ F Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Makical Examiner must be notified at Maryland St. Mary's Leonardtown 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 22680 Cedar Lane Court 20650 United States Funera 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritai Stetus 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married of Health end Mental Hygiene. Item 27 is marked other than "natural", or 1 ☐ Yes 2 ■ No Specify: Specify: White by 3 ☐ Widowed 4 ■ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance Industry 8 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Lest) Aquilla C.T. Bosley Eliza Hahn 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Joyce Bosley, Daughter 3505 Norwood Court, Waldorf, Maryland 20602 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State o Department of Important: If It any injury or one 1 ■ Burial 2 □ Cremation 3 □ Pairpoval from State Prospect Hill Cemetery 11-26-99 Towson, Maryland 4 Donation 5 Other (Specty) 22. Name and Address of Fecility Brinsfield Funeral Home, P.A. Edward N. Brinsfield Jr.,M00052 22955 Hollywood Rd., Leonardtown, MD 20650-0279 callions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Pert1. Enter the diseese, or complice shock, or heart failure. List only one Approximete Intervai Between Onset end Death ysician Medical Immediate Ceuse (Final year (ancest disease or condition resulting in death) Examine Examiner POSSIGIE 995 gangren physician and s the buriel-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medicai Due to (or as a consequence of): 8 USB ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? page 2 s 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No l or Attending Physician: efter death. director 25. Was case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify) 1 Yes 2 No 2 27. Menner of Deeth 28b. Time of Certification: 28a. Date of Injury (Month, Dev Year) 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) end manner es steted.

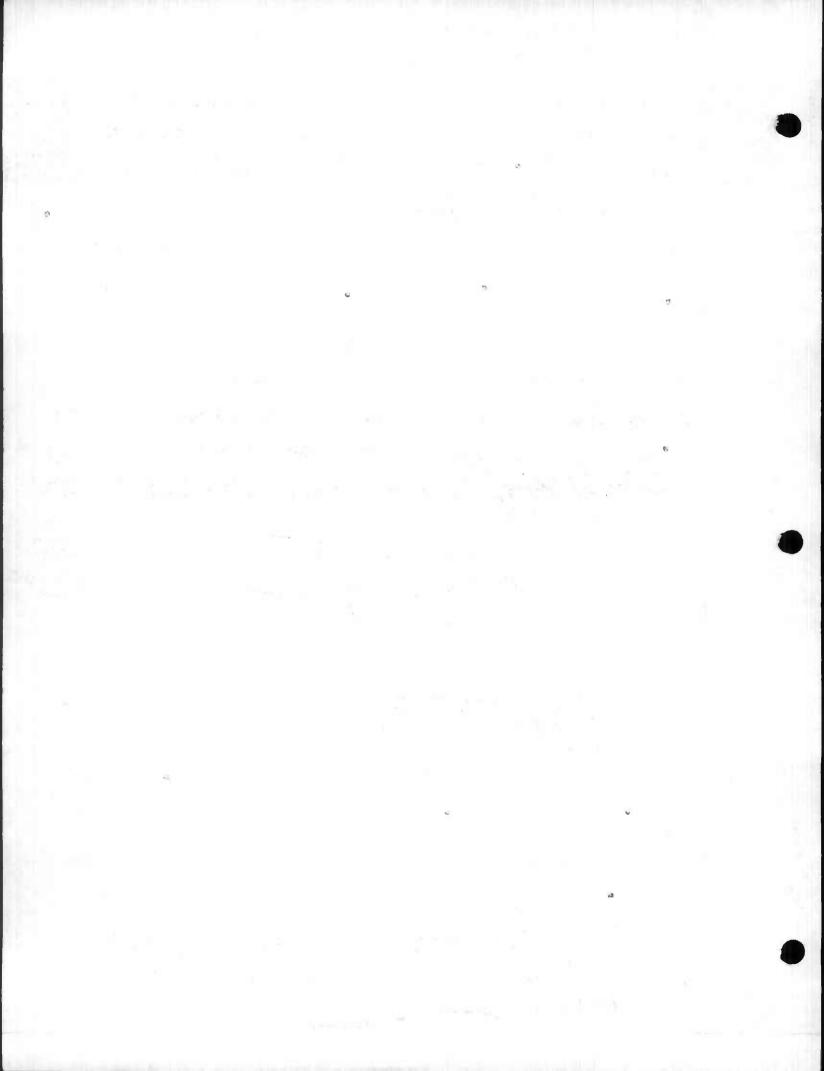
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of certifier 29d. Dete signed (Month, Day, Year) 47066 nah 11-20.99 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) DR. AVANI D. SHAH HOLLYWOOD, MD. 20636 31. Dete filed (Month, Day, Year) NOV 22 1999 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

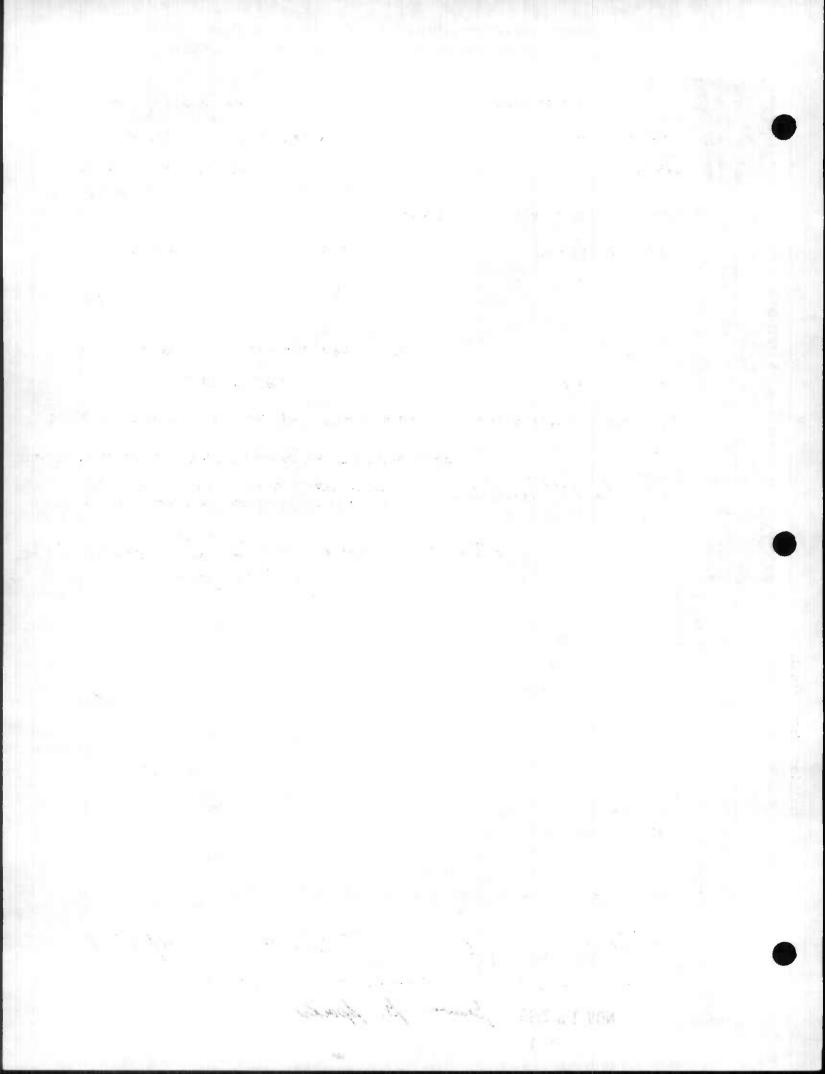
37865 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Deeth **Physician** November 22,1999 Mary Edith Bowles 5:33 a.m. /Medical 4e. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Birthplaca (Stete or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 ■ F 220-50-5540 93 Yrs. Director Maryland Usual Rasidance of Dacedant 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 28a-f show r than "naturel", or items 23a or 28a-f show the Medical Examiner mast be notified at Maryland St. Mary's Avenue Director 1 ☐ Yas 2 ■ No the 10g. Citizan of What Country?
United States 10e. Street and Number 10f. Zip Coda 20609 20454 Bowles Road Funeral filed within 72 hours after death 12. Was Dacedent Ever in U.S. Armed Forcas? 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ■ No If Yes, Give 1 □ Navar Married 2 □ Married White Maryland 21215-0020 1 ☐ Yas 2 ■ No Specify: þ 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) n/a Homemaker 8 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 900.8. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumema) Mary Roberta Ellis John Benjamin Brown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) 22485 National Circle, Lexington Park, MD 20653 Diane Sparks, Granddaughter Baltimore, 20b Pleca of Disposition (Neme of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata charles Memorial Gardens 1 ■ Buriai 2 □ Cramation 3 □ Ramoval from State 11-27-99 Leonardtown, Maryland 4 Denation 5 Othar (Specify) 22. Nama and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 unaral Service Lice Sward N. Brinsfield, pr., M00052 23a. Part1. Entar the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onsat and Death Physician /Medical immadiata Causa (Final diseasa or condition rasulting in daath) Examiner Examiner Sequantially list conditions, If any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting In daath) Last Box 68760, physician that the death certificate be Physician/Medical 2 Due to (or as a consequence of): gribnette Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, P.O. 8 23b. Did tobacco use contribute to the cause of death? yd bengir 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 8 24a. Was an autopsy 24b. Wara eutopsy findings Completed available prior to complation of causa of death? NIF certificate has **Dage 2** 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ■ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 1 ☐ Yas 2 No Division of Sign of the last 28a. Data of Injury (Month, Day Year) unecal 27. Mannar of Death 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? Affec 1 5 Panding Invastigation Attending 1 Matural 1 Yas 2 No 2 Accident after death Director. 6 Could not be datarmined 3 Suicide 28f. Location (Straet end Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica bullding, atc. (Specify) 4 Homicida 29a. Cartifian Medical 🖆 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. (Check only one) To the Hor within 24 h To the Fur Medical Examinar. On Ma basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signatura and tilla o 29d. Data signed (Marth, Dev. Year) of person who complate 30. Nama and addras causa of daath (Itam 23a) (Type, Print)? M.D., 24035 Three Notch Rd., Hollywood, MD 20636 James Pathick Jarboe,/ M.D., 32. Registrar's Signatura State 1999 Sparker Registrar

Been Bowles



		1. Decedent's Name	(First Mid	dle [set]		_			tificate	, 0,	Dean		2. Date of D	Reg. No.	99	3	3. Time of Dea	th
Physician /Medical	1	Willia			Bozes	5							Month Novem	ber 1		Year L999	7:50	
Examiner		la Facility Name (If n			eet and nu	m <i>ber)</i>							cation of Dea			of Death		
Funeral Director		45655 No 5. Social Security Nur 007-24-740	mber	6. Sex	1 2 F	7. Age	(In yrs. las	birthday) Yrs.	If Under Months	Year		Mil r 24 Hrs. Min.	8. Dale of B (Month, D June 16	irth		9. Birth Cou Ma	place (State or For ntry)	reigr
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is marked other aumatic event, I To Be Co	1	17. Father's Name (Fi		2.9								other's Name (First, Middle, Maiden Surname)						
traumatic event,	2	Joseph B			B.1.1			401-11-11	Marie Rostude Vachon						in Code's			
	- 1	19a. Informant's Nam Elizabeth				160		19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45655 Norris Road, Great Mills, Maryland 206										
other t	-	Elizabeth L. Bozes/Spouse 45655 No. 20a. Method of Disposition 1 Disposition 3 Removal from State 20b. Place of Disposition (Na. cemetery, crematory or of the cemetery).									tion (Name of Date 20c, Location - City or Town, State							
Y O H		1 N Burial 2 □ 4 □ Donation 5			noval from	State	cem	erery, cren	natory or of	ner pia		meters	, 11/12/	99 Te	vind	ton P	ark, Maryl	arr
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o the Hospital of Aftending Physician: The law requires that the death centric 24 hours start death. Within 24 hours attendation. To the Fundational Director: After this certificate has been signed by the attending completaly filled in by the funeral director, page 2 should be datached for use as completed for the fundation: To Be Completed by Physician/Me	שפקומו ספו ווובפונטוי ו כ ספ סטווליונים לא בוא פונים השפקומו די בי	disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter Under Cause (Disease or in that initiated events resulting in death) La Part II. Other algnification of the condition of the	ditions, nediate ying injury is ast conditions. Set to medic to medic to the condition investigation of the condition of the	d d d d d d d d	spital: 1 _ 28a. Date (Monace Sound	Do Do Do Do Do Do Do Do Do Do Do Do Do D	Due to (or a due t	s a consequence of a co	quence of): quenc	A Other work of the state of th	ven in Par 26. Planher: 4 1 Nry at rk? Ty at rk?	t I.	23b. Di 15 24a. Wa per 16. (Check only me 5 The 28d. Describ 28f. Location City or 7	d tobacco Yes 2 as an autoprformed? Yes 2 yone) Sidence 6 e how injury (Street annown, State, e cause(s) e, date and	use cool No Sy Signature A Number Signature Si	24b. Was a construction of the construction of	to the cause of de obably 4 Unik Vere autopsy findin vallable prior to ompletion of caus of death? Yes 2 No	esth unow
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DHMH 16 Rev 6/95



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Funeral Director	5. Social Security Number 213-24-7564		x 7	'. Age (In yrs. less	birthday) Yrs.	If Under Months	1 Yeer Deys	If Under Hours	24 Hrs. Min.	8. Data of Bi (Month, D August	rth ey, 30,1911	9. Birthplece (Stete or For Country) Maryland			
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be notified	10e. Street and Number			101. Zip Code Street 21740							10g. Citizen of Whet Country?				
nant mark	11 West Bal	Ltimore			110	Was Dass			ining /Co		U.S.A.	- American Indian,			
if, or thems 23s Examiner must.			Armed Ford 1 Yes, Give Yeer or De	2⊠ No				Specify:		ecify Yas or N Rican, etc.)	Bleck Specify:	White, etc. white			
		Decedent's Edu	cetion		6a. Dece	el Occup	ation			16b. Kind of Bus	inass/Industry				
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ked other ic event,	17. Fether's Neme (First, Mar	Middla, Last) yberry	Gifft					18. Mothe	er's Name		a Holmes				
and M summer	19a. Informent's Neme/F	per, City or Town, S	tata, Zip Code)												
127	Dana Gene K	Dana Gene Kees - grandson 219 E. Whitlock Avenue, Winchester, Virginia 2260 20a. Method of Disposition (Neme of Data 20c. Location - City or Town, State													
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ifficate hes for, page 2										10	Yas 2 No	1 ☐ Yes 2 No			
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After : After e funer		Panding investigation	28a. Data of (Month	Injury 28 Day Year)	b. Time o tnjury	f M	28c. Injun Wor 1 🗆		No	28d. Dascribe	how injury occurre	d			
\$ 5 £ 0	3 ☐ SuicIde 6 ☐	Could not be								28f. Location (Street end Number or Rural Route Number, City or Town, Stete)					

Medical Certification: To Be Completed by Physician/Med Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No 24b. Ware autopsy findings avellable prior to complation of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Wes case referred to medical examinar?

1 Yes 2 No 26. Place of Deeth (Check only one) 1 Inpatient Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of tnjury 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how injury occurred 28c. Injury et Work? 1-X Natural 5 Panding investigation 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 - Homicida 29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, data end place, end due to the causa(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end manner stated. 29c. Licansa number

29d. Dete signed (Month, Day, Year) 028365

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Strat-HAGERS 70WH 09021740 JSHAF1

State Registrar

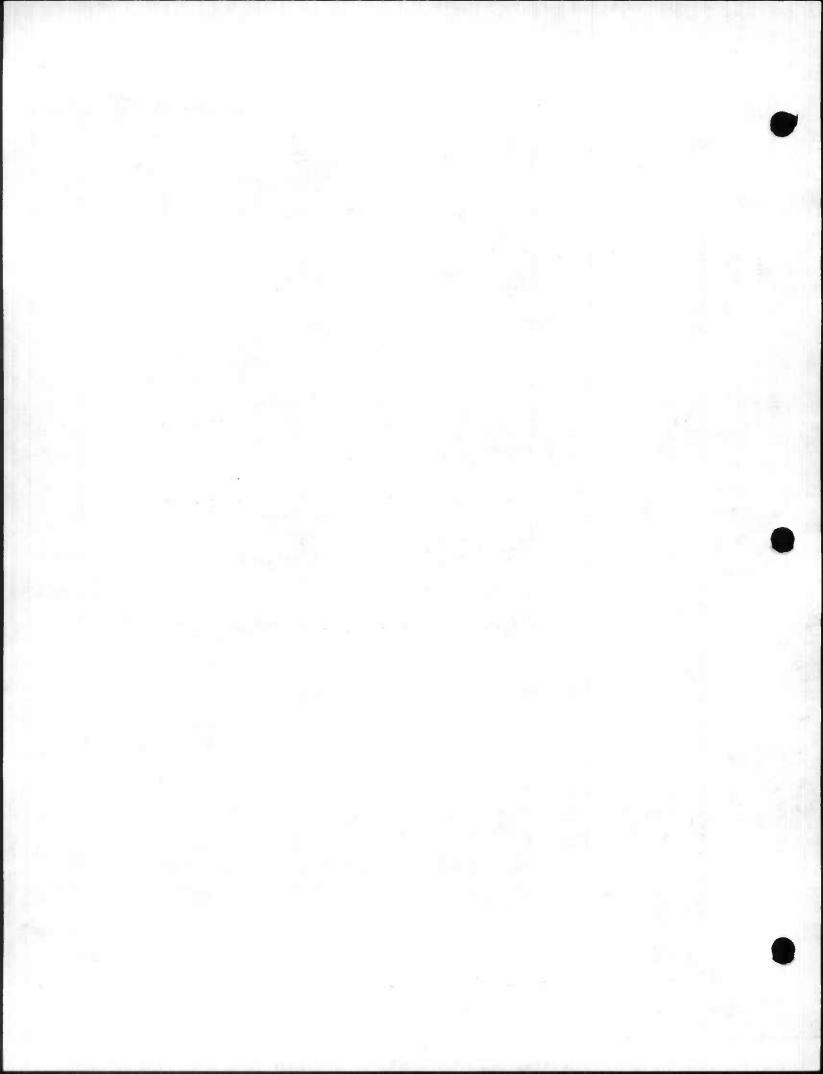
To the Hospital or Attanding Physician: The law requires that the death certific

within 24 hours after death. To the Funeral Director: A

Baker

Mary

Evelyn



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Wilbur Walker Black 10:25 AM NOV 99 15 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 1146 Woodland Way Hagerstown Washington County Months Deys Hours Min. 8. Dete of Birth (Month, Dey, May 10, 5. Sociel Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthdey) 12 M 2□ F 220-24-3807 67 Yrs. Pennsylvania Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Washington Co. Hagerstown 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21742 1146 Woodland Way U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedeni of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Maritel Stetus Bleck, White, atc. 1 Yes 2 No If Yes, Give Yeer or Detas: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packaging & Supply Co. Sales 12 6 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fethar's Neme (First, Middle, Last) Harry Wilbur Black Madge Walker 19b. Meiling Address (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Raletionship (Type, Print) Mary M. Black/Wife 1146 Woodland Way, Hagerstown, Maryland 21742 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata Hagerstown, Maryland Rest Haven Cemetery Nov.18 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Color mmeman ease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, in List only on a cause on each line. 23e. Pert1. Enter the de shock, or heer la Approximete tntervel Between Onset end Deeth Immediata Causa (Final Malisnent 6 month, Dua to (or es e consequenca oi): Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Causa (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy lindings eveilable prior to 24e. Wes en eutopsy completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Pleca oi Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Rasidenca 6 ☐ Other (Specify) 1 Yes 2 No 28d. Describe how Injury occurred 27. Menner of Deeth 28c. Injury et Work?

Physician /Medical Examiner

the death certificate be executed

law requires that

The

Attending Physician:

this

After

death.

To the Hosp within 24 hor To the Fune completely fi

Division of Vital Records, P.O. Box 68760,

permit. Peges Department of Important: If it any Injury or o

Physician

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Director

r 28a-f show

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Completed

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Peges 1 and 2 should be filed within 72 hours after death with the Meryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0020

I is marked other than "natural", or items 23a or traumatic evant, the Medical Examiner must be a

Examiner physician and the burief-transit use as t signed by the a d be detached f certificate has b lirector, page 2 s

Physician/Medicai funeral Certification: te Hospital or Attendi n 24 hours after death. Ne Funersi Director: A pletely filled in by the f

þ Completed Be 10

3 ☐ Suicide 4 Homicida 29a. Cartifiar Medical (Check only one)

1 Naturel

2 Accident

5 Pending Invastigation

6 Could not be datamined

28e. Dete of Injury (Month, Day Year)

28e. Place of Injury - At homa, farm, street, fectory, offica building, atc. (Specify)

28b Time of

1 ☐ Yes 2 ☐ No

29c. License number

28I. Location (Streat end Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To tha best of my knowledga, deeth occurred at the tima, data and place, and due to the ceuse(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of cartifier

meloward MO 041667

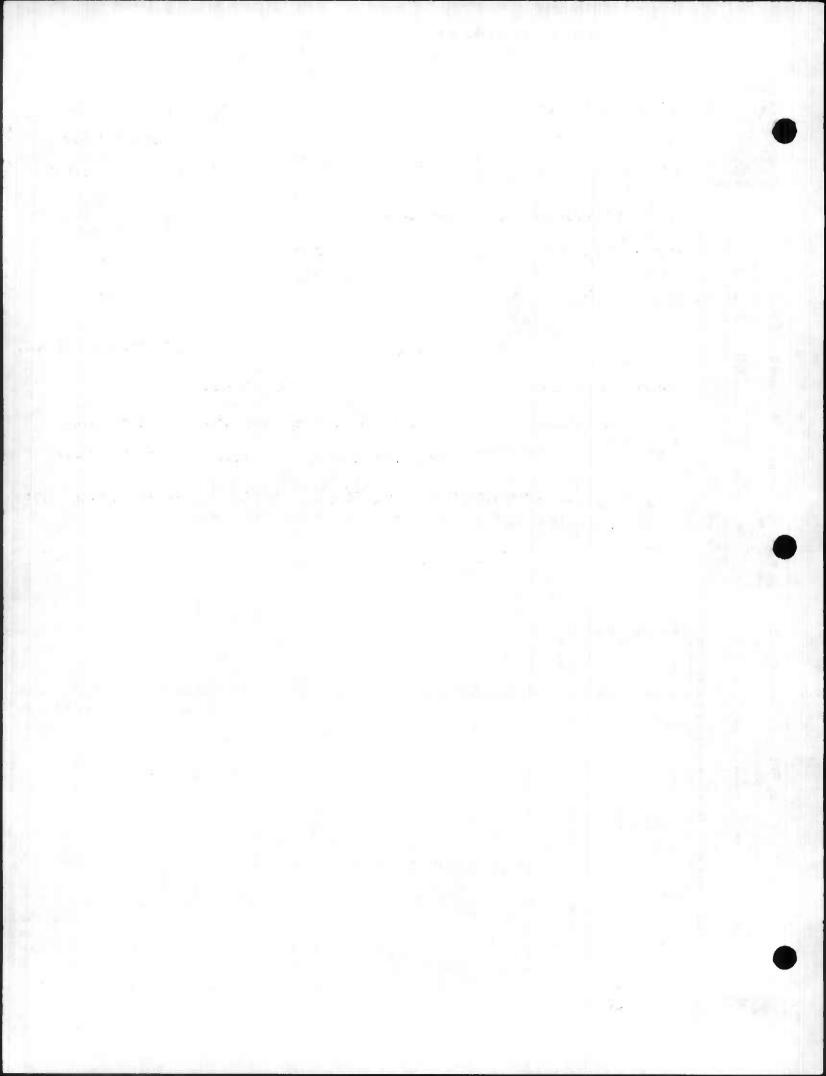
29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McCormack 11118 32. Registrer's Signature

Medical Carper, Rd. Juin 130 Hazers foury MD

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** 1999 1:55 Gladys Lorene Bartholomew NOV. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Goodwill Mennonite Home Grantsville Garrett If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Yea Mar 27, 1 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Deys 1 □ M 2 ₩ F Hours Yrs. 78 1921 220-07-6977 Maryland **Director** Usual Residence of Decedent the Maryland 10e Stete 10c. City, Town or Location 10b. County 10d Inside City Limits ehow. rithan "naturel", or items 23s or 28s-f ehov the Medical Examiner must be notified at 1 Yes 2 □ No Director Friendsville MD Garrett 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code with 21531 927 Second Avenue USA death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Rece - American Indien, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or item any injury or other traumatic event, the Healtest Exercises once. ☐ Yes 2 XNo f Yes, Give 1 ☐ Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify white p 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) Postal Clerk US Postal Service 12 th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Charles Frazee Daisy Thomas 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Edgar S. Bartholomew/husband 927 Second Ave., PO Box 74, Friendsville, MD 21531 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ₺ Burlal 2 □ Cremetion 3 □ Removel from State Blooming Rose Cem., Nov. 20, 99 Friendsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Newman Funeral Homes, P.A., PO Box 275 umai 23a. Part. Erset the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, and feilure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** immediate Ceuse (Final disease or condition resulting In deeth) /Medical ESDITA Examiner Examiner 10 certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last burial-tran Due to (or es e consequence of): P.O. Box 68760. physician Physician/Medicai the Due to (or es e consequence of) 80 attending USB for the 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, ð 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy Completed peen page 2 2 12 10 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? e Hospital or Attending Pl n 24 hours after death. e Funeral Director: Attar th Aftar 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination/end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier completely (Check only one) To the Vithin 2 29d. Date signed (Month, Dey, Year) 29b. Signeture end tittle of certifier 29c. License number 40 mn NOV. 18 1999

of death (Item, 23a) (Type, Print)

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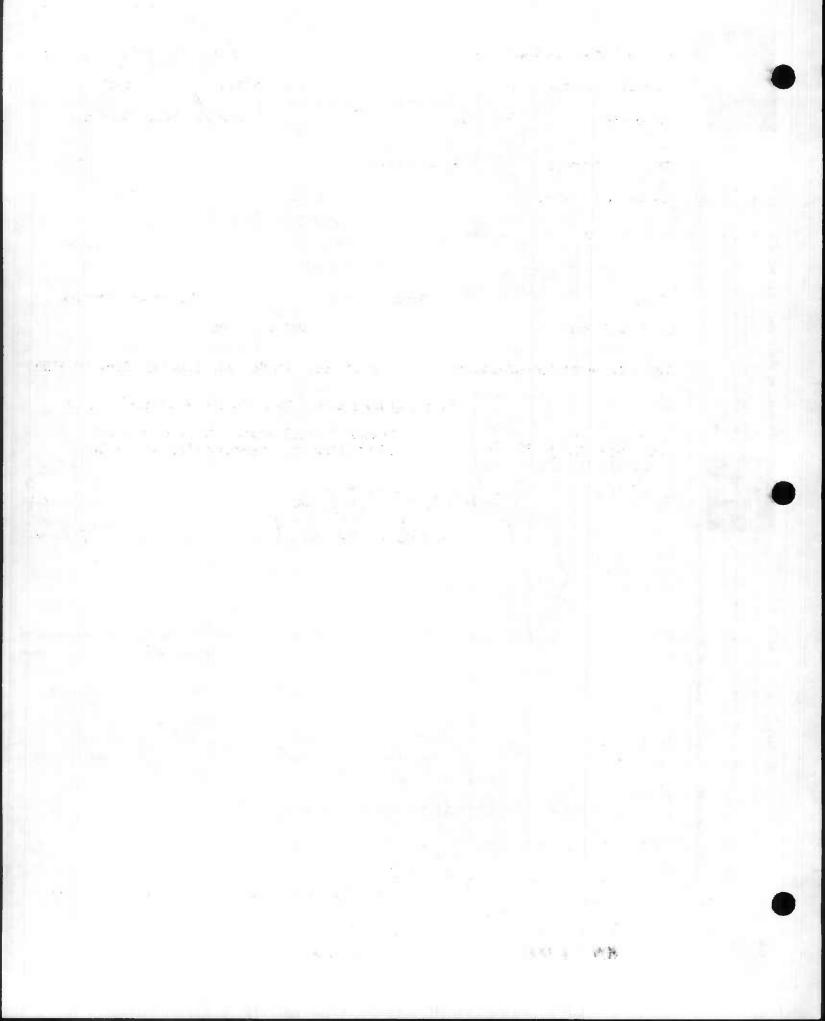
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30. Neme and adminis of parson who completed care

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32. Registrer's Signeture

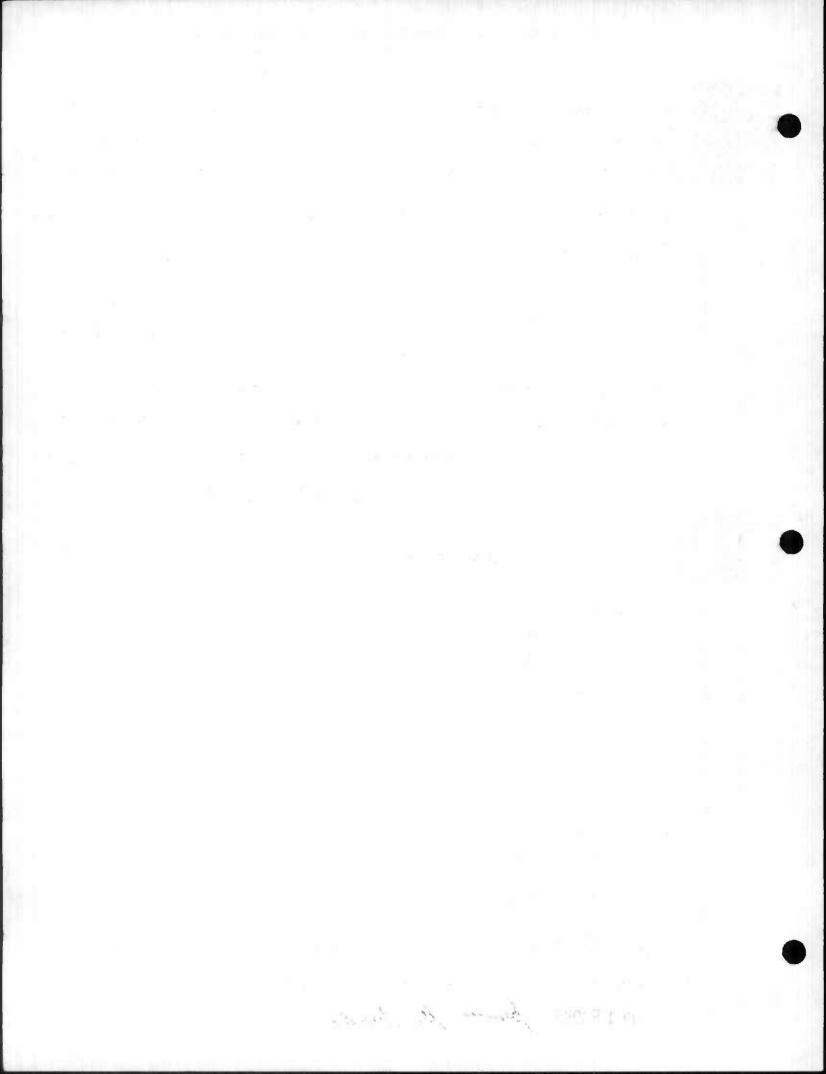


State of Maryland / Department of Health and Mental Hygiene

9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 7:20 pm John November 15, 1999 Leroy Connor /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** West Lanham Hills Prince George's 7733 Garrison Road If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 180 M 2□ F Months Yrs. 216-20-1912 Director 85 Sept. 1914 Washington, DC Usual Residence of Decedent death with the Merylend 10a. Stete permit. Pages 1 and 2 should be filed within 72 hours efter death with the Menylan Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, its featless Examine I man to nother traumatic event, its featless Examine I man to nother traumatic event, its featless in the featless in t 10b. County 10c. City, Town or Location 10d. Inside City Limits West Lanham Hills Maryland Prince George's 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7733 Garrison Road 20784 U.S.A. by Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 N Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) Government Printing Elementery/Secondery (0-12) College (1-4or 5+) Office Monotype Caster 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Aloysius Connor Mary Margaret Rabe 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John T. Connor - Son 7733 Garrison Road, West Lanham Hills, MD 20784 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Burlel 2 ☐ Cremetion 3 ☐ Removal from State 11/19/99 Suitland, Maryland 4 ☐ Donetlon 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funerel Service Licanses 22. Name end Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD Dasch -0). 20781 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** immediate Cause (Final disease or condition resulting In deeth) /Medical 1 YEAR PROSTATE CANCER Examiner Due to (or es e consequence of) Examine iclan and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that injured events.) Due to (or es e consequence of) physician s the burie Box 68760. Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 80 for use P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were eutopsy findings avelleble prior to completion of cause of death? page 2 should Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 🗓 No Other: 4□ Nursing Home 5 Residence 8 □ Other (Specify) Certification: To After this funeral 27. Menner of Death Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 X Neturel efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Sulcide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

| Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) end menner steted. Medical 29a. Certifier completely (Check only one) To the 29b. Signeture end title of certifier 29c. License number 29d. Data signed (Month, Dey, Yeer) 10 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Rita Gupta, M.D., 8926 Woodyard Road, Suite #201, Clinton, Maryland 31. Dete filed (Month, Dey, Year) Registrer's Signeture State Registrar NOV 1 8 1999

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q Q

							Cei	rtificat	e of	Death		Reg. No.	9 3	78	71	
	Physic	ian	1. Decedant's Nama								2. Date of De Month		Year	3. Time	e of Death	
	/Medi		JOSUE 01								NOVEMB	ER II,	1999	2:	35 AM	
	Exami		4a. Facility Name (If	not Institution, giv	e street and num	iber)				4b. City, Town, or I	ocation of Deat	th 4c. Cour	nty of Death			
	_		NATIONAL							Bethesda			gomery			
	Funeral		5. Social Sacurity Nu		Sex IXIM 2□ F	7. Age (in yrs.	. last birthday)	If Under Months			8. Data of Bid (Month, De	rth a <i>y, Year)</i>	9. Birth	place (Stantry)	te or Foreign	
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Baltimore,	permit. Pege Department of Important: If any Injury or pnce.		21. Signature of Fun	eral Sarvice Ligar	1399		1 22	2. Name ar	nd Addr	ass of Facility			LBULL	u, 11	ondara	
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	Physician		Mock, or heart	failure. List only	ona causa on as	ich line.							i	Onset a	Between and Death	
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	the deeth ce y the ettendi sched for use	sici	Part II. Other signific	ant conditions o	ontributing to de	ath but not res	sulting in tha u	ndarlylng o	ausa g	ivan in Part I.	23b. Did	tobacco use o	contributa t	o the cau	se of death?	
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Ö	o a a a a a a a a a a a a a a a a a a a	Ser	4 Nornicida		Dullain	g, atc. (Speci	ny)				City or 10	iwii, Siaia)				
	Hospital 24 hours of Funeral I	al	29a. Certifiar	Certifying Ph	ysician: To the I	est of my kno	owledge, death	occurred	at the t	ime, dete end plece	, end due to tha	cause(s) end	menner as s	teted.		
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Certification:	(Check only 2 one)	∟ Medical Exam	niner: On the ba and mann	sis of axamini ar statad.	ation and/or Inv	vastigetlon	, in my	opinion, daeth occu	rred at the tima,	, data and place	e, and dua t	o the caus	5 0 (S)	
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				J. MAC			900	O ROO	CKVI	LLE PIKE,	BETHES	SDA, MAI	RYLANI	208	192	
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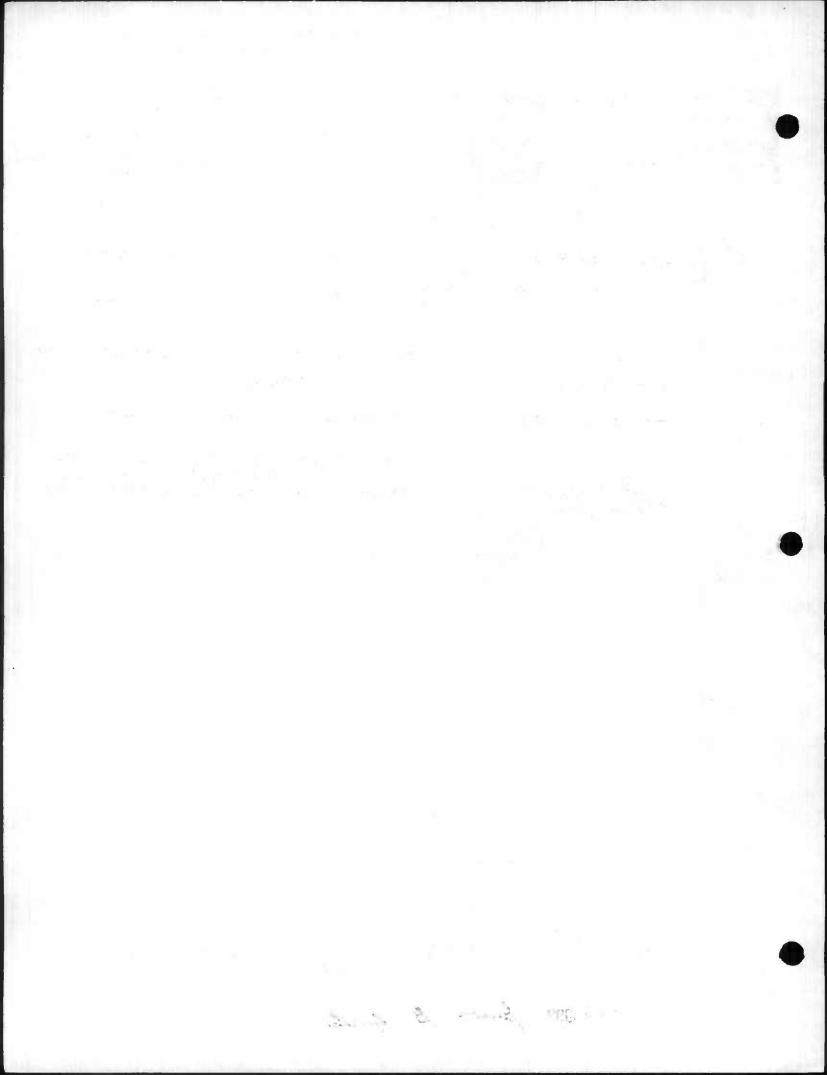
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Childress NOVEMBER 14, 1999 J.B. 5:23 P.M /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CAMP SPRINGS PRINCE GEORGE'S MALCOLM GROW MEDICAL CENTER If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month Day, Ye OCT 13, 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country)
Tenn **Funeral** 261 14 8698 1 □XM 2 □ F Deys Hours Yrs Director Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at P.G. Forestville MD Director 1 Yes No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 United States Herna 23a 20747 2701 Shelton Place death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. should be filed within 72 hours after of Mental Hygiene.
merked other than "naturel", or ites 1XX es 2 No 1942 If Yes, Give Yeer or Detes: 1945 1 Never Married Married Baltimore, Maryland 21215-0020 1 Yes 2KNo Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Residential Property Property Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Peges 1 and 2 should be fill ment of Haath and Mental Hant: If Item 27 is marked oth jury or other traumatic even Unknown Arthur Childress 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
2701 Shelton Place, Forestville, Maryland 20747 19e. Informent's Name/Relationship (Type, Print) Mary J. Childress (WIFE) 20a. Method of Disposition

14 Burial 2 Cremetion 3 Removel from State 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, State permit. Pege Depertment o Important: If I eny injury or once. Resurrection Cemetery Nov 18,1999 Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signeture of uneral Service Licensee Alexandria Ferry Road, Clinton, Maryland 20735 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel 1 HOUR CARDIO PULMONARY ARREST disease or condition resulting in deeth) Examiner Due to (or es e consequenca of). Examiner CORONARY ARTERY DISEASE 5 YEARS The law requires that the death certificata be axecuted physicien and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. Physician/Medicai Due to (or es a consequence of) for use es P.O. signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? page 2 certificeta 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice stell filled in by the funeral director, F Be 25. Wes case reterred to medical 26. Place of Deeth (Check only one) exeminer? Hospitel: 1 ☐ Inpatient 2 🏋 ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) #977 Taire NOVEMBER 14, 1999 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 89 MDG/1050 W PERIMETER RD RUTH A. ROBINSON, COL, USAF, MC ANDREWS AIR FORCE BASE, MD 20762-6600 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar NOV 1 6 1999

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State of Maryland / Department of Health and Mental Hygiene 99

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Felton Anderson, MD 11418 Livingston Rd. Ft. Washington, Md. 20744 31. Date filed (Month, Day, Year) 32. Begistrer's Signeture 4	\leq	or Al	TIL.	determined	286. Piece of injury	r - At home, fer (Specify)	m, street, fector	y, office		28f. Location City or To	on (Street and Number or Rurel Route Number, Town, State)				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Felton Anderson, MD 11418 Livingston Rd. Ft. Washington, Md. 20744 31. Date filed (Month, Day, Year) 32. Begistrer's Signeture 4		ne Hospin 24 ho		(Officer Offit) Z Medical Exam	niner: On the basis of ex	caminetion end	deeth occurred /or investigation	at the tin , in my o	ne, date and ple pinion, deeth oc	ce, end due to the curred et the time	ceuse(s , dete en	end menne d place, and	er es sta due to	ated. the cause(s)	
30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Felton Anderson, MD 11418 Livingston Rd. Ft. Washington, Md. 20744 31. Date filed (Month, Day, Year) 32. Begistrer's Signeture A		To t	Σ	29b. Signeture end title of certifier	100		29	c. Licens	e number		29d. De	te signed (A	Month, E	Jey, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Felton Anderson, MD 11418 Livingston Rd. Ft. Washington, Md. 20744 31. Date filed (Month, Day, Year) 33. Begistrer's Signeture A		0			D/:11	82									
Felton Anderson, MD 11418 Livingston Rd. Ft. Washington, Md. 20744		12/	1	30. Neme and address of pareon who	completed cause of door	th (Item 22a) /7		D411	04		11,	/10/99	1		
State 31. Dete filed (Month, Day, Year) 39. Registrer's Signeture		('/						t. W	ashinot	on Md 2	0744				
Registrar NOV 1 6 1999 Segure B. Locales		Cto	to							ongilu. Z	0794				
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State of Maryland / Department of Health and Mental Hygiene 3787L Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** NOVEMBER William Chasko 1999 John 8:01A.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Leonardtown St. Mary's St. Mary's Hospital If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) July 12, 1921 9. Birthplece (Stete or Foreign Country) New York **Funeral** 1X M 2 F Months Devs Hours 077-18-2976 78 Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland St. Mary's Abell 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with natural', or items 23s or USA 20606 38872 Chasko Road Funeral 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours efter 1y Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 □ Divorced feer or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within . Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than * any Injury or other traumatic event, the Mac poince. Elementary/Secondary (0-12) College (1-4or 5+) 8 years Oral Surgeon Dentistry 12th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Ethel George Chasko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 11 Deer Run, East Haddam, CT 06423 Greg Chasko (Son) 20b. Pleca of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from Stete 12/1/1999 Charles Memorial Gardens Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licegisee 21. Signeti 22. Neme end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 e, or complications that caused the dan List only one cause on each line. not enter the mode of dylng, such es cardiac or respiretory errest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last and physician a s the buriel-1 Box 68760. Physician/Medical the USB 85 ettending p ed by the e Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the under 23b. Did tobacco use contribute to the cause of death? s been signed by ti 3 Probably 4 € Unknown 1□ Yes 2□ No Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? hes page 2 certificete 1 Yes 2 10 No 21 No Vital i or Attending Physician: after death. Director: After this certific director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2E18 1 Impatient Certification: To 2 ☐ EP/Outpatient 3 ☐ DOA o 27. Mann 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 26c. Injury at Work? Division 1 DNatural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 | Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in Le Continuing Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated.

Wedical Exampler: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the control of the cont 29a. Certifier Medical ner: On the basis of exemination end/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29b. Signature and title of certifie 29d. Dete signed (Month, Day Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) DR. DAVID FEDERLE PHILIP J.BEAN MEDICAL CTR. HOLLYWOOD, MD 20636

State Registrar 31. Date filed (Month, Day, Year)

NOV 3 0 1999

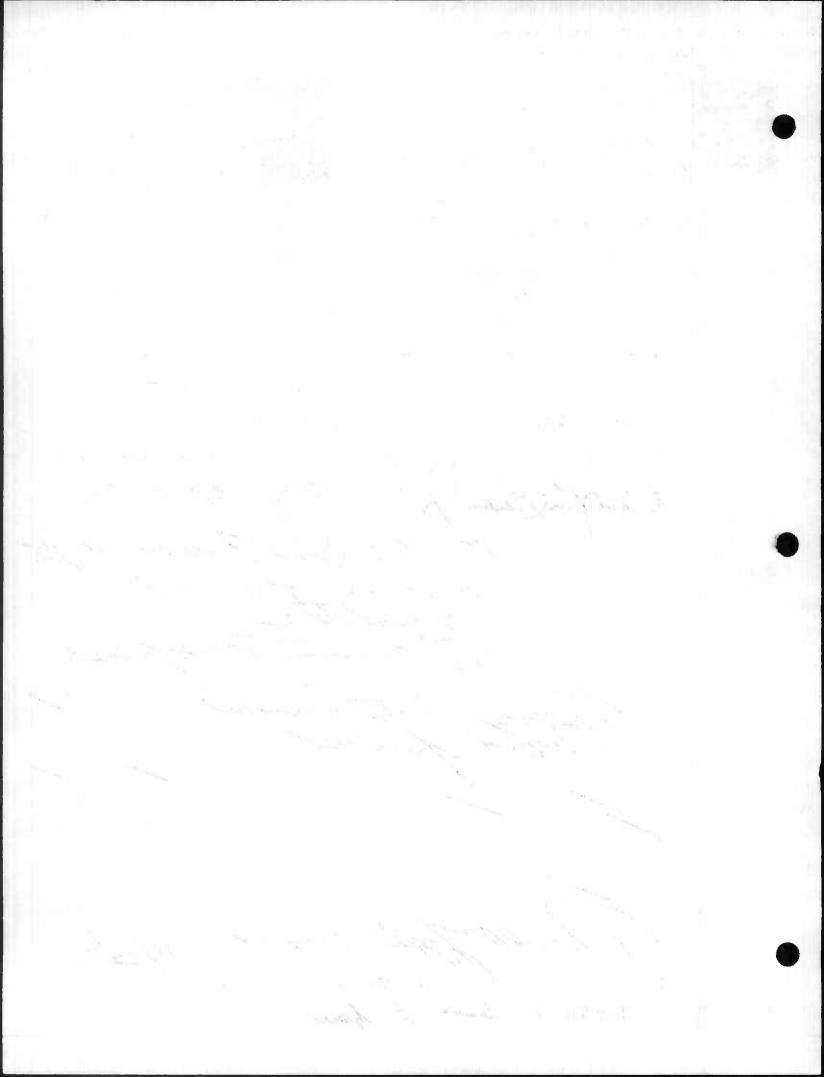
32. Registrer's Signature

souls

DHMH 16 Rev 6/95

CHASKO

WILLIAM



Physician

/Medical

Examiner

To Be Completed by Funeral Director

Funeral

Director

	Plea	ase Type or State		nd / De	epar	rtment	nt of H		Mental Hygi	iene q		37875	
1. Decedent's Name	e (First, Midd	ile. Last)			50, 0	mount	J 0.	Doutti	2. Dete of Death	eg. No.		3. Time of Death	
		liam Copse	ev. Sr.								1999	06:39AM	
4a. Facility Name (In								4b. City, Town, or I		4c. County		00101	
St. Mar	ry's Ho	ospital				*****		Leonardto	own	St. M	ary's		
5. Social Security N 217–18–685	50	6. Sex 1∆ M 2□ F	7. Age (In yrs.			If Under Months				1922	Cour	place (Stete or Foreign http) yland	
Usuel Residence of 10a. State	10b. County	J .	10c. C	City, Town o	or Loc	ation					1	Od. fnside City Limits	
Maryland		Mary's		Great								1 ☐ Yes 2 No	
		Mary 5	,	JIEau	, PII		0:40						
10e. Street and Nun						10f. Zip			10	Og. Citizen of		itry?	
45908 Cha	irles W						0634			U.S.A			
11. Marital Status 1 □ Never Marri 3 □ Widowed		rried Armed F	s 2□No Give	J,S.	lf \	/as Deced Yes, speci ☐ Yes 2	cify Cubi	Hispanic Origin? (Span, Mexicen, Puerto Specify:	pecify Yes or No- o Ricen, etc.)		ce - Americack, White, fy: Whi	etc.	
10	15. Deceder	nt's Education		16a. [Decede	ent's Usua	al Occur	pation		16b. Kind of B			
Elementary/Secon	cify only highes	est grede completed	d) (1-4or 5+)	(%)	(Give ki life. DC	rind of won O NOT us	ork done se retired	i during most of wor ad)	king				
8th				22	eat:	food	Dea			Seaf			
17. Father's Name (Solomon									me (First, Middle, M Morgan	leiden Sumen	ne)		
19a. Informent's Ne		_		19b.	Meiling	a Address	Stree	_	ural Route Number,	City or Town	Stete, Zir.	Code)	
Roger Way			n						hanicsvil				
4 Donetion	☐ Cremation 5 ☐ Other (S)		m State	Zion I	, c <i>iem</i> e Unit	etory or other	eth. (Cemetery 1	11/8/99 M		wille,	Maryland	
21. Signature of Fu	roelf	Ligensge	ner						r Funeral				
23a. Part1. Enter the shock, or hear	ne disease, or rt failure. List	r complications that t only one cause on	caused the dea eech line.			_						Approximete Interval Between Onset and Death	
Immediate Cause (I disease or condition resulting In death)		e. Se		OPL (or as a co			- 6	or Pul	monal	,	6	years	
Sequentially list con	nditions.	b. ——		(or as a co									
if any, leeding to im ceuse. Enter Under Ceuse (Disease or I that Initiated events	nmediate erlying Injury	с											
resulting in deeth) L	.ast		Due to (d	(or as e cor	nseque	ance of):					1		
		<u> </u>									1		
Part II. Other significant	cant condition	ons contributing to a	en lo	sulting In the	fr und	lerlying ce	euse giv	/en in Part I.		bacco use co	ontribute to 3 ☐ Prof	bably 4 Unknown	
Hyper	ter	scor							24a. Was an perform		ev-	ere autopsy findings eileble prior to mpletion of ceuse death?	
U									1 □ Yes	s 2) No	1[Yes 2000	
25. Was cese referrexaminer?	red to medica'	.i						26. Place of Der	ath (Check only one	9)			
1 Yes 2	No	Hospital:	Inpatient 2	⊒ ER/Outp	patient	3 DO	DA Oth	ther: 4 Nursing H	Home 5 ☐ Resider	nce 6 🗆 Ott	her (Specif	(y)	
27. Manner of Death 1 Netural 2 Accident	h 5 🗆 Pendin investig	ng (Moi	e of Injury onth, Dey Year)	28b. Tin			28c. Injur Wor		28d. Describe ho			,,	
3 ☐ Sulcide 4 ☐ Homlcide	6 Could r determ	not be lined 28e. Plec built	ce of Injury - At h Iding, etc. (Special	nome, farm	n, stree	et, factory	, office		28f. Location (Str. City or Town,		ber or Rura	al Route Number,	
29a. Certifier (Check only	Cartifyin 2 Medical	ng Physician: To the Examiner: On the t	ne best of my kno basis of examina anner stated.	owledge, o	deeth c	occurred e	et the tir , in my (me, date end place opinion, deeth occu	, and due to the ca irred at the time, do	use(s) and me ite and place,	enner as s , end due to	tated. the cause(s)	

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the deeth certificeta be executed within 42 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burlet-transit Division of Vital Records, P.O. Box 68760,

/Medical

Examiner

16

DR. JAMES C C. 31. Date Med (Month, Day, Year) State Registrar

29b. Signature and title of cert

BOYD ALIFORNIA. MD. 20 CALIFORNIA, MD. 20619 12. Registrar's Signeture

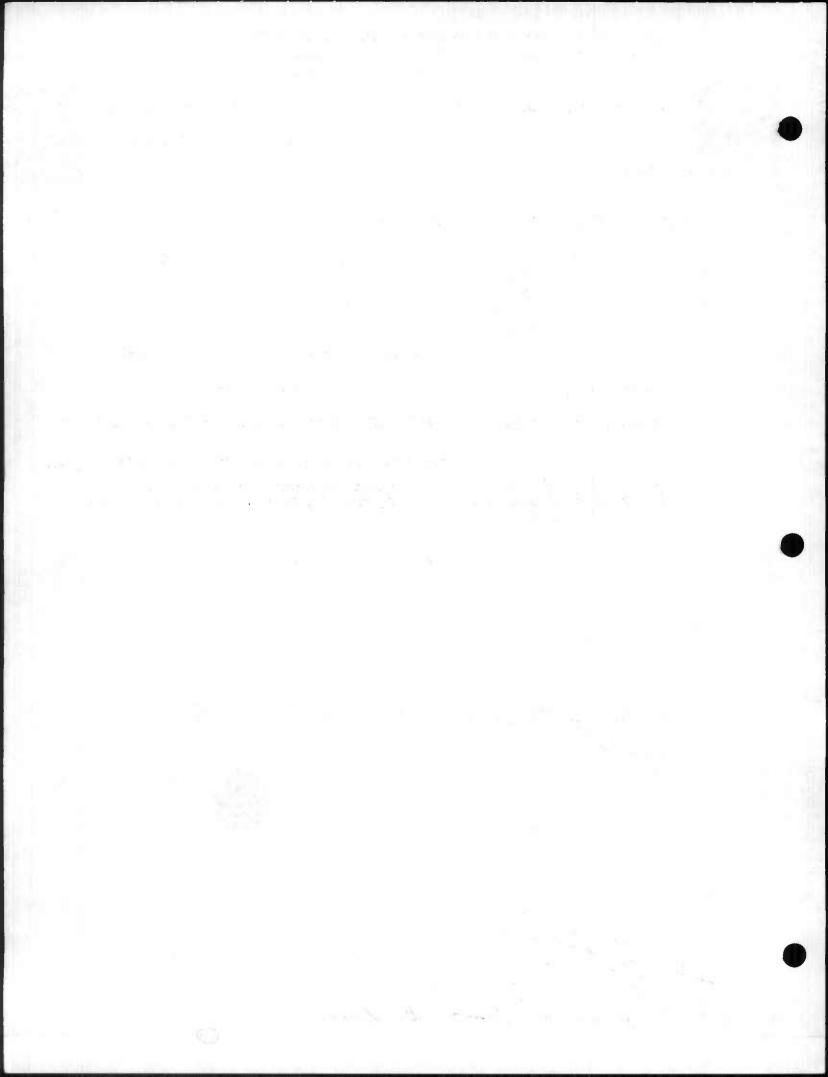
porks

29c. License number

9917

29d. Date signed (Month, Dey, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Ce	ertificate o	f Death)	Re	eg. No. 9 9	3	7876					
	1. Decedent's Name (First, Middle, La	ist)			2. Dete of Deeth 3. Time of Deat										
Physician	Maria Roberta (Carrico					Month November	Dey er 11.	1999	10:10PM					
/Medical Examiner	4a Facility Neme (If not institution, gir				4b. City, Te	own, or Lo	cation of Death	4c. County		10.10111					
Examiner	15150 Oaks Road				Char	lotte	Hall	Hall Charles							
Funant		Sex 7. Ag	e (In yrs. lest birthde	() If Under 1 Ye	ar If Under		8. Date of Birth (Month, Dey,			lece (State or Foreign					
Funeral Director		1□ M 2ŪXF	102 Yrs.	Months De	/s Hours	Min.	(Month, Day, June 27,	ne 27, 1897 Maryland							
lend lend	10e. Stete 10b. County		10c. City, Town or	Location					1	0d. Inside City Limits					
death with the Maryland rms 23a or 28s-f show Errust be notified at	Maryland Charle	S	Charlo	tte Hall			1.			1 ☐ Yes 2 🛣 No					
O siter death with the Ma ir feme 23e or 28ed s ning must be notified Funeral Directoi	10e. Street and Number 15150 Oaks Road			10f. Zip Code 2062			1	10g. Citizen of Whet Country?							
ter death w	11. Maritel Stetus	12. Wes Decedent	Ever in U.S. 13			rigin? (Spe	cify Yes or No-			- American Indian,					
020 urs efter of, or the	3 X Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 X I If Yes, Give Yeer or Detes:	No	. Wes Decedent of If Yes, specify C 1 ☐ Yes 2 🖾 N			Rican, etc.)	Specify	ok, White, o	etc. nite					
15-00% naturel; and call Expense instance.	15. Decedent's E	ducation	16e. Dec	edent's Usuel Oc	cupation	nt of sundeb		16b. Kind of Bi	usiness/ind	dustry					
12 Page 12 Pag	Elementary/Secondary (0-12)	College (1-4or 5	+)	e kind of work do DO NOT use ret memaker	ired)	St OF WORK	ng .	Own He	ome						
	17. Fether's Neme (First, Middle, Last	")			18. Moth	er's Name	(First, Middle, M								
Maryland 2: d 2 should be filed w d 2 should be filed w d 2 should be filed w T is marked other to treumatic event, to T o Be Col	Levin Canter				Elizabeth Woodburn										
Shound Mind Mind Mind Mind Mind Mind Mind Mi	19a. Informent's Neme/Reletionship	Type, Print)	19b. Me	iling Address (Stre	et end Numb	per or Rure	l Route Number	City or Town,	Stete, Zip	Code)					
Nore, Marylisges 1 and 2 should to Health and Mer If Hem 27 is marke or other treumstic	Bettie Ann Gatton	/ Daughter	Road,	Char]	Lotte Ha	ll, Ma	rvlan	d 20622							
Health Health Hem 27 other tr	20e. Method of Disposition	Bettie Ann Gatton/ Daughter 15150 Oaks Road, Charlotte Hall, Mary 20e. Method of Disposition 20b. Place of Disposition (Name of commetery, cremetory or other piece) 20c. Location - City													
Baltimore, M permit. Peges 1 end permit. Peges 1 end Important: If fem 27 any Injury or other tr once.		fy)	St. Mar	y's Ceme	tery		11/15/99 Bryantown, Marylan								
Balting permit. Per Department Important: any Injury once.	21. Signature of Funeral Service Lice														
	23e. Pert1/Enter the disease, or com	plicetions that caused	the deeth. Do not e	nter the mode of o	lylng, such es	Leona s cardiac o	r respiretory error	est,	and_2	Approximete					
Physician	shock, or heart feilure. List only	one ceuse on eech III	10.	1	,		/		1	Intervel Between Onset end Deeth					
/Medical	Immediate Cause (Final disease or condition	Com	estive	602	1-7	Sil	lus			huer					
Examiner	resulting in deeth) Due to (or as a consequence of):														
		14.	-11 (i)	- trice	5/2	21/19	5 7		4	54K					
cuted and ransi	Sequentially list conditions, Due to (or es a consequence of):														
68760, ficete be executed the buriel-transit st the buriel-transit edical Examiner	if any, leeding to immediate cause. Enter Underlying								i						
filicate be explicate by physician as the burie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es à consequence of): Due to (or es e consequence of):														
		d.													
P.O. BOX that the death cer by the ettendin deteched for use															
orhed y the	Pert II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause	given in Pert	1.				the cause of death?					
that the ed by the detech							1 Y	es 2 No	3 Prol	bably 4]() Unknown					
N 8 6 8 0							24e. Wes e	n eutopsy	24b. W	ere eutopsy findings					
The law requires the law requires the law requires the last been signed, page 2 should be completed by							perform	med?	CO	elleble prior to mpletion of ceuse death?					
VICAL THE LAW sician: The law s certificate has b director, page 2 s							1 🗆 Ye	s 2No	10	Yes 2□ No					
sician: Trenticate irector, pa	25. Wes case referred to medical				26. Plac	e of Deeth	eeth (Check only one)								
OT VICE Physician: this certific ral director,	exeminer?	Hospital:	ent 2 ER/Outpet	ent 3 DOA	Other:		me 5 Reside		ner (Specif	(v)					
0 5 5 7	27. Manner of Deeth	28a. Dete of Inju (Month, De	ry 28b. Time		njury et Vork?	-	28d. Describe ho								
atio	1 Naturel 5 Pending Investigation		y Year) Injury		Yes 2	No									
DIVISION C belor death. et Director: After t led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not b	256. Piece of inj	ury - At home, farm,	street, factory, offi	ce	1			ber or Rura	al Route Number,					
de de la companya de	4 Homicide	building, et	c. (Specify)				City or Town	1, 3(8(8)							
To the Hospital or Attending Physician 24 bours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	29a. Certifier Check only one) Certifying Pi	nysician: To the best of	examinetion end/or	ath occurred et the investigetion, in m	time, dete e y opinion, de	nd plece, e	end due to the co	euse(s) end ma ete end place,	anner es s' and due to	leted. the ceuse(s)					
thin 2 the maple		end menner sta	1180.	29c Lie	ance number		2	9d. Dete signe	ed (Month	Day Vaerl					
Twin To	29b. Signeture and title of certifier	Beach	ke in		ense number	500		ad. Data signi	/	5					
1	30. Neme end eddress of person who	completed cause of d													
(9)	Leon W. Berube	•	Mecha er's Signature	nicsvill	e, Mar	ylan	20659								
State Registrar	NOV 1 5 19		A.	Spar	6										

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedenl's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Death Yaa **Physician** Dorothy Nellie Crombie November 11, 1999 /Medical 2:22 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Teonardtown
| Irunder24 Hrs. | 8. Date of Birth (Month, Day, Year) St. Mary's St. Mary's Nursing Center
5. Social Security Number 6. Sex 7. Age (In If Undar 1 Yaar 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2XF Days Yrs. Director 215-20-3295 August 12, 1924 Maryland Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Insida City Limits r 28a-f show 1 ☐ Yes 2 No Director Fairfax Virginia Alexandria 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 7 is marked other than "natural", or items 23s or traumatic event, the Modical Examiner must be 5703 LaVista Drive permit. Peges 1 end 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event. 22130 U.S.A. Funeral 12. Was Decedani Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, atc. 11. Marital Status 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 ☐ Yes 2 💆 No Specify: à 3 Widowed 4 □ Divorced White Completed 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Security Assistant Central Intelligence 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maldan Surnama) Be George Garner Gibson Ida Pearl Russell 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8550 Wild Game Lane, Owings, Maryland 20736 Date 20c. Location - City or Town, S Judith MacWilliams/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery 4 □ Donation 5 □ Other (Specify) 11/13/99 Bushwood, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650.

Part Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx. Shock, or heart failura. List only one cause on each lina. Approximata Interval Between Onsal and Death **Physician** Immediate Causa (Final disease or condition rasulting in death) /Medical Examiner with Dementer Physician/Medical Examiner Tremore physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 98 use (signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificate hes b director, pege 2 s 1 ☐ Yes 2 No or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Ngrsing Homa 5 Residence 6 Other (Specify) To 1 □ Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at 28d. Dascribe how injury occurred 28a. Date of injury (Month, Day Year) 28b. Time of Certification: After 5 Panding 1 ☐ Yes 2 ☐ No invastigation deeth. 24 hours efter dee we Funeral Director pletely filled in by th 6 Could not be detarmined 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowled a death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lima, date and place, and due to the cause(s) and manner might. 29a. Cartifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of period who completed clause of death (Itam 23a) (Type, Print)

California,

32. Registrar's Signature

Maryland 20619

DHMH 16 Rev 6/95

State

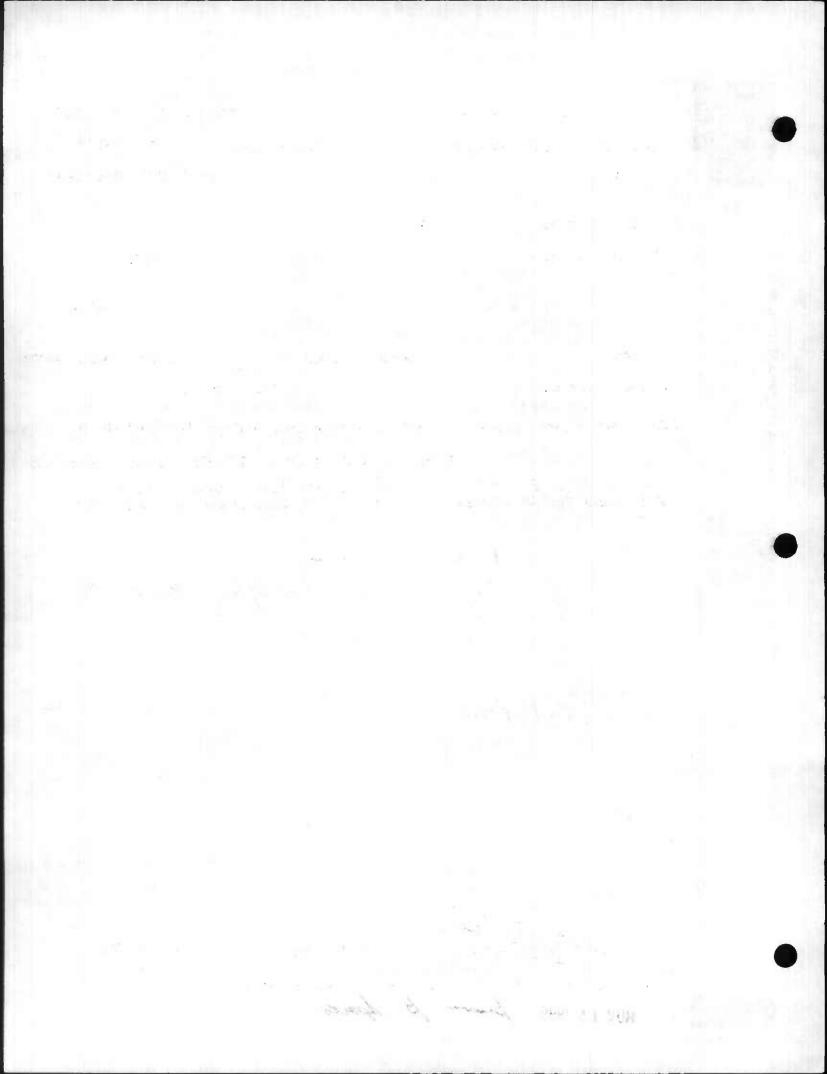
Registrar

James C. Boyd,

NOV 1 5 1999

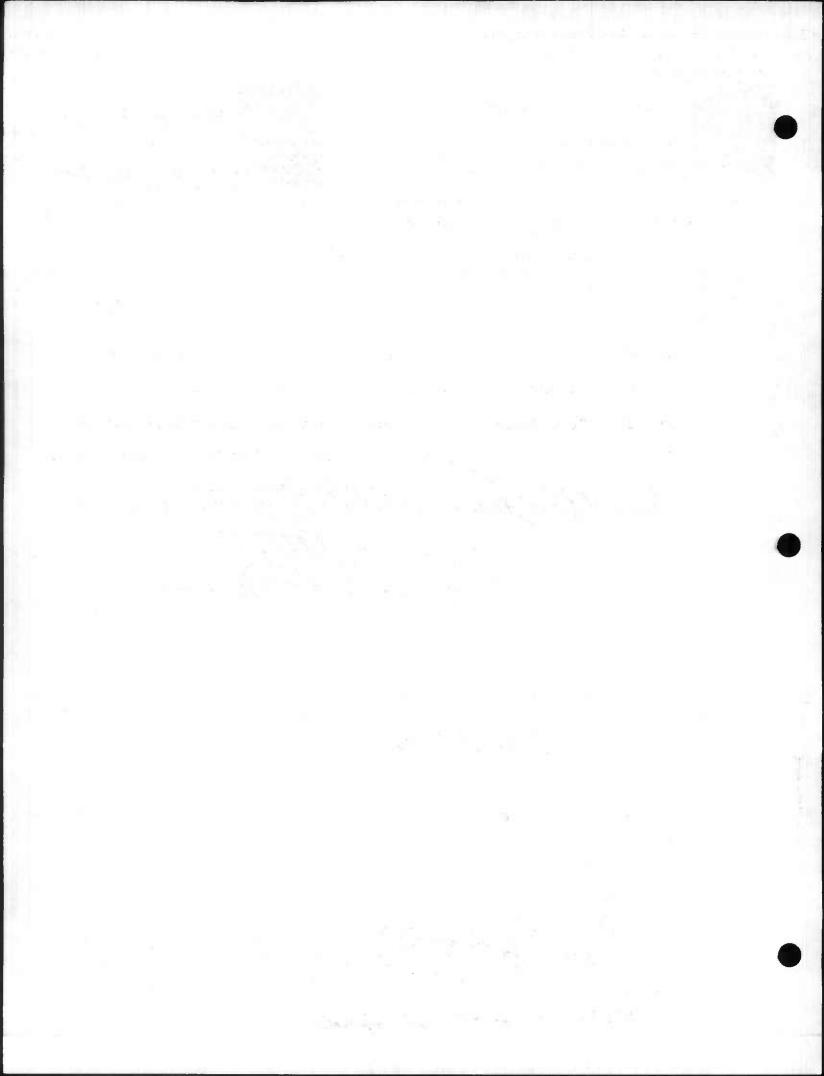
31. Date filed (Month, Day, Year)

6



State of Maryland / Department of Health and Mental Hygiene 99 37878

Physician Control Clark Service									Certifica	ate of	Deat	th		Reg. No.		210	310
EXAMPLE STATEMENT Lambert Clark Formula 4. Firstly where a first settings, you was the own relief of the control of the contr		Test and a		1. Decedent's Nama (First,	Middle, La	st)								eath	Vee	3. Tirr	ne of Death
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Physician

/Medical

Examiner

1. Decedent's Name (F

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t institution, g	rive street and number)		4b. City, Town, o	r Location of Death 4c. C	ounty of Death	12.10 111

1 Yes 2 XNo

Approximate Interval Between Onset and Deeth

2□ No

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29d. Date signed (Month, Day, Year)

November 19, 1999

Funeral

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21215-0020

Maryland

Baitimore,

Depertment of Important: If any Injury or page **Physician** /Medical Examiner

Examine The lew requires that the death certificate be executed Box 68760. Physician/Medical the 880 signed by the a Records. þ Completed certificate hes page 2 Attending Physician: Be 2 shia funeral After Certification: Division death after death Director: the ne Hospital or Atte n 24 hours after de ne Funeral Directo pletaly filled in by ti

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of Vital

Prince George's Hospital Center Cheverly Prince George's If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex M 2□ F Birthplace (State or Foreign Country) Hours 218-94-7753 August 21, 1964 35 Washington, DC **Usual Residence of Decedent** 10e. State 10b. County 10c. City. Town or Location tOd. Inside City Limits Directo Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40247 Waterview Drive 20659 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Moving Company 12th Grade Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Frederick Alfred Cain Iva May Jennison 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 40247 Waterview Drive, Mechanicsville, Maryland 20659 Frederick A. Cain Father 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State Charles Memorial Gardens 11/23/1999 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funerel Service License Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland andere 20650 23a. Part1. Enter the disease, of complications, or heart feilure. List only one that caused the de not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 200 No 1 Yee 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 X Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No. 2□ No. 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury Worth, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturat

State Registrar

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Medical

ARON 31. Date filed (Month, Day, Year) NOV 2 2 1999

6 ☐ Could not be

title of certifie

26 Accident 3 ☐ Suicide

4 I Homicide

29a. Certifier (Check only

29b. Signatyre a

32. Registrar's Signature

addrugs of person who completed cause of death (ttem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

2200

SPRET

Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

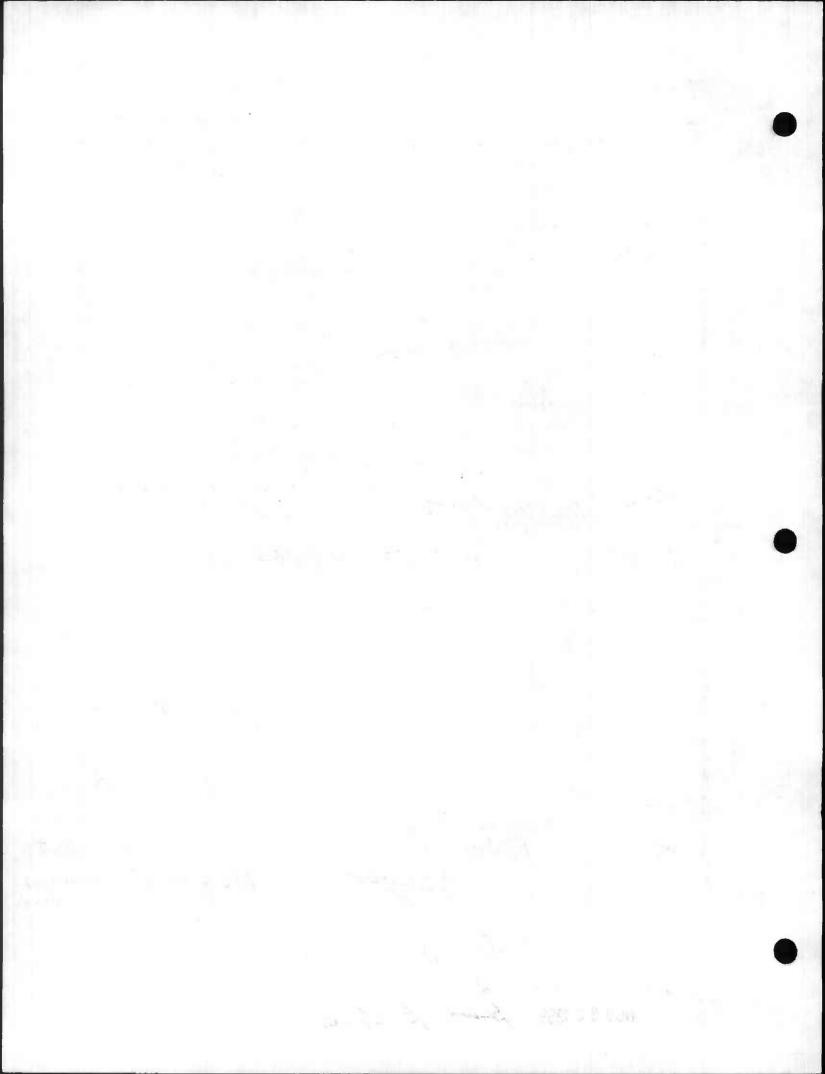
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28f. Location (Street and Number or Rurel Route City or Town, Stete)

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State of Maryland / Department of Health and Mental Hygiene Q Q 7880 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 11, 1999 **Physician** John Henry Curtis 12:25 p.m /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 25320 Vista Road Hollywood St. Mary's 8. Date of Birth (Month, Day, Ye March 8, Birthplaca (State or Foreign Country) If Under 1 Yaar | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthdey) Year 909 **Funeral** Days Min. Months Hours 1 ■ M 2 □ F 217-16-8440 90 Yrs. Maryland Director Usual Residence of Decedent the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d, Insida City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at St. Mary's Hollywood Maryland 1 Yas 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda filed within 72 hours efter deeth with 25320 Vista Road 20636 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ■ No 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: If Yes, Give Specify: Black þ 3 ■ Widowed 4 Divorcad Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Agriculture/ Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Farmer & Trash Collection Trash Company 12 marked other permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important; if Itam 27 is marked orbh any injury or other traumatic event RRBs. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Sumame) T is mark-Be Mary Nettie Thomas Marty Curtis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 5931 Hil-Mar Dr., Forestville, Maryland 20747 Mary L. Rochester, Daughter 20b. Placa of Disposition (Neme of cametery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cramation 3 □ Ramoval from State St. John's Cemetery 11-15-99 Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Fugogasarka Moores 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 Blankenship, M00857 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onsat and Death Physician /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 88 attending properties as Part II. Other stands conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? been signed by the should be datached 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? has ya 2 s certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Yes 2 ■ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Directors, completely filled in by the 6 Could not be datarminad 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida Hospitai 29a. Certifier 🔝 Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. ş 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature-and title of certifier 0 D14285 11-15-99

State Registrar 31. Data filed (Month, Day, Year)

NOV 1 6 1999

30. Name and eddress of person who completed cause of death (Itam 23a) (Type, Print)

32. Registrar's Signature

William D. Boyd II, M.D., 25365 Point Lookout Rd., Leonardtown, MD 20650 oouts

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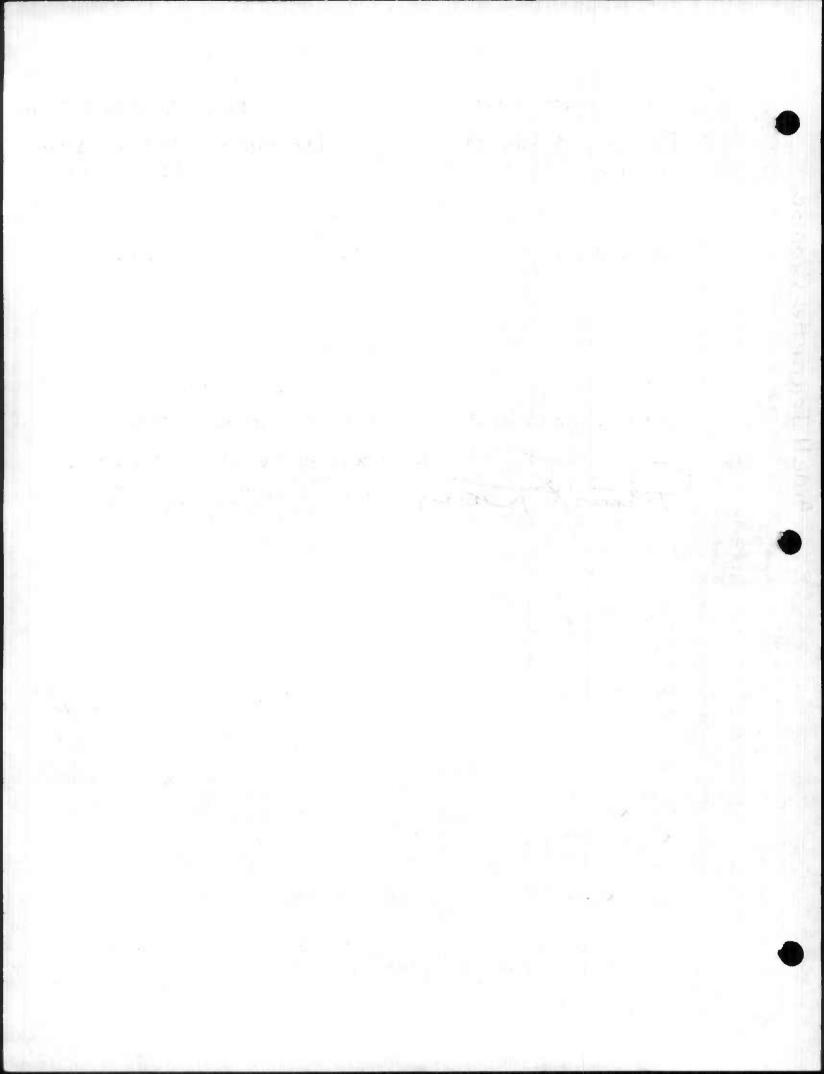
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ector		214-80-1352	1□M 2√F	87	Yrs.		7.00.0	Aug.	Birth Dev, Year) 31,1912	Mary	land
		Usuel Residence of Decedent 10e. Stete 10b. County		10c City	Town or Lo	nation				40.4.1	
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	Funeral Director		ungron		Di						Maries 2 140
	ä	10e. Street end Number 236 S. Main S	<i>L</i>			10f. Zip (Whet Country?	
	a						713			S.A.	
	une	11. Meritel Status	12. Wes Decedent Armed Forces	3	. 13.	Wes Decede If Yes, specif	ent of Hispenic Origity Cuben, Mexicen,	In? (Specify Yes or Puerto Ricen, etc.)	No- 14. Ra Bie	ce - American In eck, White, etc.	ndien,
		1 Never Married 2 Married	If Yes, Give	Wo		1 Yes 2			Speci	(11/2 :	te
	d b	3 XWidowed 4 ☐ Divorced	Yeer or Detes:							,	
	Completed by	15. Decedent's (Specify only highest of	Educetion grade completed)		16e. Deced (Give	dent's Usuel kind of work	Occupetion done during most retired)	of working	16b. Kind of E	Business/Industr	у
	d m	Elementery/Secondery (0-12)	College (1-4or	5+)	IIf⊕. I	Homen	naken		Hom	0	
		1 0 17. Fether's Neme (First, Middle, La	0.41								
	Be	Earl B. Phill						's Neme (First, Mid		me)	
	T _o							ora V. Sh			
		19e. Informant's Neme/Reletionship		1				or Rural Route Nu			le)
		Shirley E. Meta	. (Vaugnter					Boonsboro	-		
		20e. Method of Disposition 1 ☐ Burial 2 🖾 Cremetion 3	□Removal/ener State	20b. Ple	netery, crer	sition (Name metory or oth	e of her plece)	Dete	20c. Location	- Clty or Town,	Stete
		1□Donetion 5 □ Other (Spe	cify	Smi	thsbw	rg Cre	matory 1	Vov. 20, 19	99 Smith	hsburg.	Md.
any injury or		Signeture of Funeral Service Lic	elson C	\rightarrow	200	Mama and	Address of Pasilis.				
8		Danis	n	Jah.	- Do	avis F	uneral Ho	ome 12525	Bradbur	y Ave.	
		23a. Pert1. Enter the diseese, or co	mplications that cause	d the death.				SIIILLI	O LIVIUL IVIUL	41.00	rovimete
an		shock, or heert feilure. List on	ly one ceuse on each I	ine.			, , ,		,	Inte	roximete rval Between set end Deeth
i		tmmediete Ceuse (Finel	Δ.	6117	1.0	T 0	4 1				
er		diseese or condition resulting in deeth)	e. 1VG	OCANO	lier	4 1	arction	1			
	ē		0 =		es e conseq	quence of):				l.	
	Examiner		b. Se			,					
	Xai	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying		Due to (or	es e conseq	(uence of):					
		Ceuse (Diseese or Injury	c								
	9	thet initieted events resulting in deeth) Lest		Due to (or e	es e conseq	uence of):					
	X		d							i	
	Physician/Medical										
	ysic	Pert II. Other significant conditions						23b. D	id tobacco usa co	ontribute to the	cause of death?
		Dea	enrativ	P	AVIV	iviti	C	1	☐ Yes 2☐ No	3 Probably	4 Unknown
	l by					· / 1	-3			T	
	Completed							24e. W	es en eutopsy erformed?	evailebl	utopsy findings e prior to
	g									of deeth	tion of cause
	5							11	Yes 210 No	1 ☐ Yes	2 No
	Be	25. Wes cese referred to medical					26. Piece o	of Deeth (Check on			
	To 1	exeminer? 1 ☐ Yes 2 💢 No	Hospital: 1 Inpatie	ent 2 E	R/Outpetien	it 3□ DOA	Other	sing Home 5 Re		her (Specify)	
		27. Menner of Deeth	28e. Dete of Inju	iry 2	8b. Time of	280	c. Injury et Work?		e how injury occu		
	atio	1 Neturel 5 ☐ Pending investigeti		y roar,	Injury	М	1 Yes 2 N	0			
	illici	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of in	ury - At hom	ne, farm, stre	eet, factory,	office		(Street end Num	ber or Rural Rou	ite Number,
	Certification:	- LI HOHIOIGE	building, et	c. (Specify)				City of	Town, State)		
		29a, Certifier 1 Cartifying F	hysician: To the best	of my knowl	edge, deeth	occurred et	the time, dete end	plece, end due to ti	ne ceuse(s) end m	enner es steted.	
	edicai	(Check only 2 Madical Expone)	minar: On the basis o and menner st	t exeminetic	n end/or Inv	estigetion, la	n my opinion, deeth	occurred et the tim	e, dete end plece,	end due to the	ceuse(s)
	Me	29b. Signature end title of certifier				29c.	License number			ed (Month, Dey,	Yeer)
completely filled in by			2				0523 2	23	11/21	199.	
- 1	- 1	IN THE							, 0	1 19	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Was eem MP 7 48 251- R-ANTIRTAM ST HAGRESTOWN MD EP 7 48

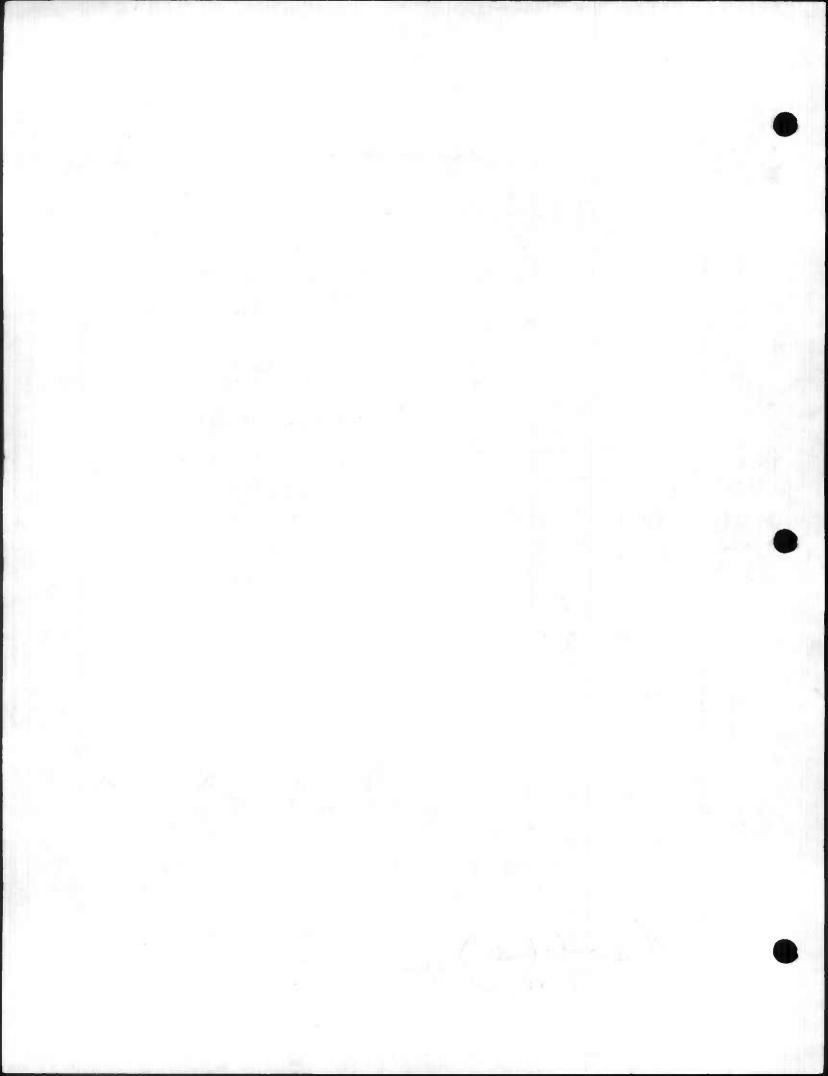
32. Registrer's Signeture

State Registrar 31. Dete filed (Month, Day, Year) NOV 2 2 1999



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

TYLOR I.	C	INE EMS: #23	R PART	State of	of Ma	aryland	/ Depa	artmen MEO rtificat	t of L	lealth a	5-2	lental Hyd	jiene 9 C) 3	7882
Physici		1. Decedent's Name	(First, Middle, Li	ist)		UA-I						2. Date of Dea Month	th Day	Yeer	3. Time of Deeth
/Media		4a Facility Name (II			umber)				4	tb. City, To	wn, or Lo	NOV .	18, 199 4c. County		0648 AM
LAMINI	1911	1317 3	AY DRIVE	3					I	HAGER	STOW	N	WASH	INGTO)N
Funeral Director		5. Social Security No.		Sex 1⊠M 2□F		e (In yrs. las weeks		If Under Months	Days 21	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Oct. 2	7, 1999		elece (State or Foreign etry) Cyland
show stat	or.	Usuat Residence of 10a. State Maryland	10b. County Washingt	on Cou	ntv		Town or Lo				Ħ			1	0d. Inside City Limits 1 ☐ Yes 2000No
the N 28a-1 Dodffu	Director	10e. Street and Nun						10f. Zip	Code				log. Citizen of W	/hat Cour	
P with	al D	1317 Jay	7 Drive							21740				U.S	.A.
Z1Z15-0020 d within 72 hours after death with the Marylar glene. In then "natural", or thems 23s or 25s-f show the Medical Exeminer must be notified at	by Funeral	11. Marital Status 1 💢 Never Marrie 3 🗆 Widowed	ed 2 Married	12. Wes Dec Armed F 1 Yes If Yes, G Year or I	orces? 2 🔯 N			Was Deced If Yes, spec			gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)	14. Rece Blac Specify.	k, White,	an Indien, etc. iite
72 ho	pete	(Speci	15. Decedent's E)		16a. Dece	dent's Usua	al Occup	ation during most	t of work	ina	16b. Kind of Bu	siness/Inc	dustry
within the Man	Completed	Elementary/Secon	1	College	(1-4or 5	i+)		DO NOT U	se retired	during most			N/A		
	To Be Co	17. Father's Name ())	- 1		1/22				(First, Middle, Lee Sta	Maiden Surnam		
y, Maryland and 2 should be file selfs and Mental Hy n 27 is marked oths ar traumatic event	-	19a. Informant's Na Jody A.						-					r, City or Town, Maryland		
Ore, of Hear of Hear		20a. Method of Disp		3		20b. Plac	ce of Dispo	osition (Nar	ne of ther place	pe)	i	Date	20c. Location -	City or To	own, Stete
L. Papes timent of t			Cremation 3 ☐ 5 ☐ Other (Speci		State			ven C			N	lov.22	Hagerst	own,	Maryland
Baltimore, permit. Pages 1 a Department of Hes important: if Item any injury or othe 2058.		21. Signature of Fur	neral Service Lice	nsee			D	ougla	s A.	ss of Fecilit Fier	y Fu	neral H	ome	Mary	land 21742
Physician /Medical Examiner	Examiner	Immediate Cause (I disease or condition resulting in death)	_	ab.		A Due to (or a	SPHY	XIA guence of): AYIN							Interval Between Onset and Death
. BOX 66/60, death carifficate be smacu e attanding physician and id for use as the burial-fra	loal	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) i.	njury \$	c		Due to (or a									
. 0 e E	Physician/Med	Part II. Other signific	cant conditions o	contributing to d	feath be	ut not resulti	ing in the u	nderlying o	ause giv	en in Part I	Pi -				o the cause of death? bably 4 Unknown
requires to been signal abould be	Completed by											24a. Was i		av co	ere eutopsy tindings eilable prior to mpletion ot cause deeth?
The law atte has page 2	E O											100	es 2 No	de	Yes 2□ No
VICIAN: The	Be	25. Was case references									of Deat	h (Check only o	ne)		`
or Attending Physical Control of Attending Physical Control of Phy	Certification: To	27. Marmer of Death 1. Matural 28. Accident 3 Suicide 4 Homicide		n 28a Date	-18	er In	WOutpatier Sb. Time of Injury UNKN e, farm, str	OWN 2	Sc. Injur Wor 1	4 LI Nu	No	28d. Describe h	ence 6 Other ow injury occurr ONTALLY AN ADU itreet and Number n, State)	od SU SM ILT I Pur	
Hospital 24 hours Fumeral Hely filled	edical Co	29s. Certifier (Check only one) /	1 Certifying Pt	nysician: To the	e best o	of my knowle examination	edge, death	оссипед	at the tin	ne, date and pinion, deat	d place, th occurr	and due to the o	ause(s) and ma	MD nner as s and due to	teted. o the cause(s)
To the within 7 To the comple	Me	A	itle of certifier	and mar				290	: Licens	e number			29d. Date signed	(Month,	Dey, Year)
- 3 - 5		W a	Front	alon	w	1			(O.C.M.	.E		NOV.	19,	1999
		30. Natura and produc	ss of person who	completed cau	so of d	eath (Nam 2			reet	, Bal	timo	re, Mar	yland 21		The second
Sta Registr	90090	31. Date filed (Mont	DV 23 19	399	Sepanya	uls-Signatur	· B.	4	park	2					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

29d. Date signed (Month, Day, Year)

11-11-99

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Physiclan The law requires that tha death certificata be executed -leunq the 80 USB datached 8 should paga 2 or Attending Physician: funeral director, After after death. filled in by 24 hours a Hospital within 2 To the I

Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month ELOISE ROMAIN CALLIS NOVEMBER 11, 1999 4:30 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 309 SENECA AVENUE MT. LAKE PARK GARRETT If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country)
 WV 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Days 1□ M 2X F Months 220-26-9665 Yrs Director 69 MARCH 14 1930 Usual Residence of Decedent the Manylend x 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director MD GARRETT MT. LAKE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 08 "natural", or itema 23a 309 SENECA AVENUE 21550 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours efter 1 Never Married 2 Married Yes 2 X No f Yes, Give Year or Dates: 21215-0020 1 Yes 2 No Specify: by Specify: WHITE 3 N Widowed 4 □ Divorced r than "nature the Medical I Сопрете and Mental Hygiana.

and Mental Hygiana.

T is marked other than 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Peges 1 end 2 should be I nent of Health and Mental I ARTHUR EARL FRIEND **EMMA** SAVILLA MOON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Health em 27 i BRIAN E. CALLIS - SON 309 SENECA AVENUE MT. LAKE PARK, MD 21550 Department of Health Important: If item 27 any Injury or other t 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/99 OAKLAND, MARYLAND OAKLAND CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 au 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting In deeth) acute myocardial infarction Due to (or as a consequenca of) Examiner atherosclerotic cardiovascular disease Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) Box 68760, lung cancer 3/98 Physician/Medical that initiated events resulting In death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1X Yes 2 No 3 Probably 4 Unknown by of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Was an autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier TX CertifyIng Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

CMedical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical (Check only one)

State Registrar

NOV 1 5 1999

Donald Richter M.D.

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

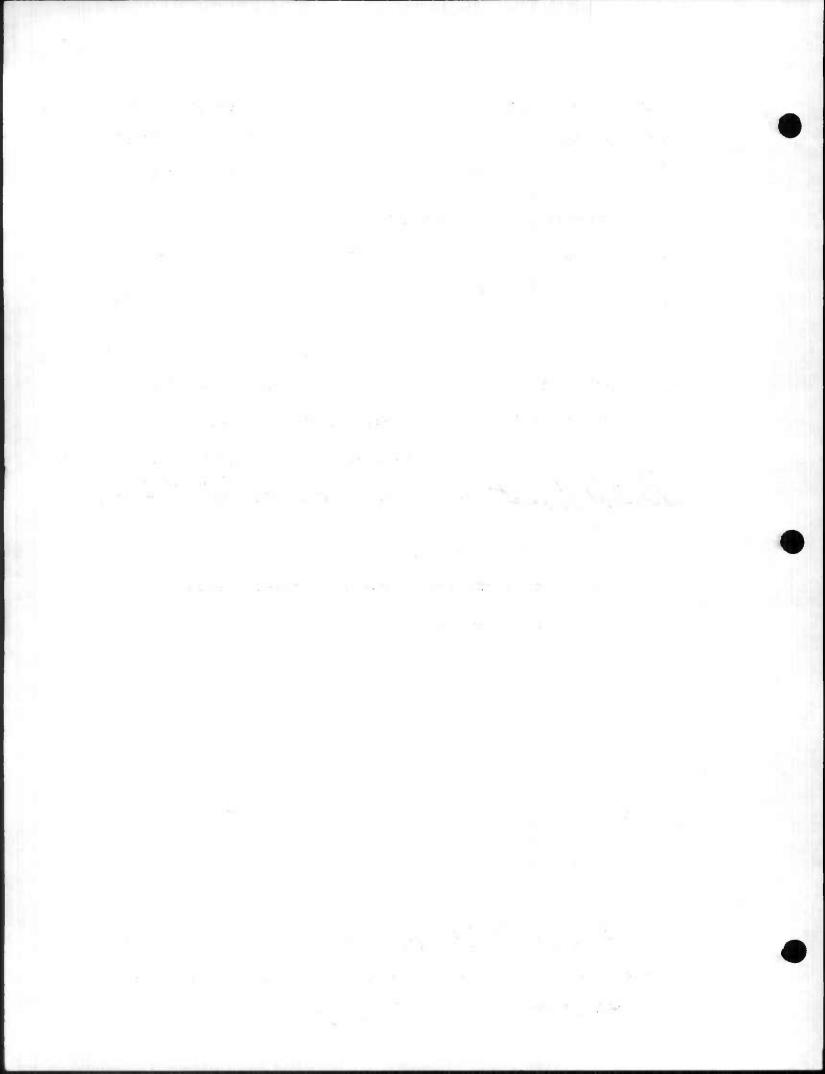
29b. Signeture and title

32. Regigtrar's Signature



29c. License number

D30035



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

			State of Marylar		ent of Health and ate of Death		giene Reg. No. 9 C	37881
		1. Decedent's Neme (First, Middle, L	ast)			2. Date of Dee	eth Dey	3. Time of Death
	Physician /Medical	Janet Cornel	ia Davis				4, 1999	
	Examiner	4e Facility Neme (If not institution, g	ive street end number)		4b. City, Town, o	r Location of Death	4c. County	of Death
		1617 Clearview			Oxon Hi			e Georges
г	Funeral		Sex 7. Aga (In yrs.	Yrs. If Ur	der 1 Year if Under 24 Hi hs Days Hours Mi	n. (Month, De		Birthplaca (Stata or Foreign Country)
	Director	579-72-4222 Usuel Residence of Decedent	47	110.		Dec. 15	, 1951	Virginia
	dand dand	10a. State 10b. County	10c. Ci	ty, Town or Location				10d. inside City Limits
	Man Help	MD. Prince	Georges Ox	on Hill				1 ☐ Yes 2 ☐ No
	vith the Marie of contract of Director	10e. Street and Number	ocorgeo on		Zip Code		10g. Citizen of W	Vhet Country?
	th will	1617 Clearview	Ave		20745		USA	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show mith plury or other traumatic event, its Medical Examiner must be inculted at ance. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Dacedant Evar in U Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Dates:	if Yes,	ecadent of Hispenic Orlgin? specify Cuban, Mexican, Pus s 2 A No Specify:	(Specify Yes or No- arto Rican, atc.)		e - Amarican Indien, ck, Whita, etc.
0-0	2 ho	15. Decedent's 6	Education	16e. Decedent's U	Jsuel Occupation	and in a	16b. Kind of Bu	usiness/Industry
215	ed within 72 hours sygiene. The Medical Example Completed by	(Specify only highest g	College (1-4or 5+)	life. DO NO	Jsuel Occupation work done during most of w T use retired)	rorking		
7	Hygiene. Hygiene. Inther than ent, Italie Comple		3yrs	Staff A	ssistant			ical Center
pu	d oth	17. Fether's Neme (First, Middle, Las	<i>t</i>)			ame (First, Middle,	Maiden Sumem	Θ)
2	should be nd Mantal marked o umatic ev			1.00 1.00		Mosley	- Ci - T	0 7. 0.4.
Mai	ith and T is mi	19e. Informent's Name/Reletionship Derek Davis/Son	(Type, Print)		ress (Street end Number or			
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noi	Pages nent of I int: If ite	1 Deuriel 2 Cremetion 3	Hemovel from Stete	cematery, cramatory		111 10 00	Cuitle	nd MD
altimore,	Department Department Important: I any Injury opnce.	4 Donetion 5 Other (Spec			National Cem	11-19-99	Sultia	nd, MD.
B	Departing Imports any Injury	1	Quarter)	Marsh	all's Funera			
m	Section 1	23a. Pert1. Enter the disease, or conshock, or heert feilure. List only	volicetions that ceusad tha dea	4308 th. Do not enter the r	Suitland Rd.	Suitlan	rest. MD.	20746 Approximata
H	Physician	shock, or heart feilure. List only	y one ceuse on each line.			, , , , , , , , , , , , , , , , , , , ,		Intervel Between Onset end Deeth
	/Medical	Immediate Cause (Finel	Matastatia	Colon Con	ani nama			2 months
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	rate be axecuted hystolan and the bunal-transit dical Examiner	Sequentially list conditions,	Due to (or es e consequence	of):			
9	olan a	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury						
8760,	physician s the bun	thet initiated events resulting in death) Lest	Due to (d	or es e consequence	of):			
9	ding passes as		d					
Вох	as that the death certific igned by the attending p be detached for use as by Physician/Mex					1		
P. 0.	the d	Pert II. Other significant conditions	contributing to death but not res	sulting in the underlyle	ng cause given in Pert I.			ntributa to the cause of death?
	that the ded by deta					10	Yes 2□No	3 Probably 4 Unknown
Records,	The law requires that the late has been signed by th page 2 should be detached.						an eutopsy	24b. Were autopsy findings
000	The law require cate has been si page 2 should Completed					perto	rmed?	avellable prior to completion of cause of death?
æ	e has age 2					10	res 2 No	1 ☐ Yas 2 ☐ No
ta	certificate rector, pag	25. Was case referred to medical			26. Place of D	eath (Check only o		
2	hysicia his cer al direc	exeminer? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpetient 3	Other:	Home 5 K Resk		er (Specify)
0	g Physical distribution of the Total distrib	27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe I	now injury occur	red
0	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by tha funeral director, page Medical Certification: To Be Com	1 Naturel 5 Pending investigeti	on	M	1 ☐ Yes 2 ☐ No			
Division of Vital	or Atter de Directe IIn by t	3 ☐ Suicide 6 ☐ Could not determine	28e. Pleca of Injury - At h building, etc. (Speci		ctory, office	28f. Location (3 City or Tox		per or Rurel Route Number,
Ω	iled in							
	To the Hospital within 24 hours To the Funeral completely filled	(Check only 2 Madical Exa	hysician: To the best of my knorminar: On the basis of exemine					
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((0)	30. Neme end eddress of person who			ded or m	TT 1- 1		0. 20002
	State	William J. Cul 31. Dete filed (Month, Dey, Year)	1en, M.D. 1		oitol St. N.E	. wasnir	igton, D	C 20002
	Pegietrar	NOV 1 8 1999	here	6 1	***			

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State of Maryland / Department of Health and Mental Hygiene

29d. Date signed (Month, Day, Year)

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sician		. Decedent's Name			()								Month	. De	y in	Yeer	1	75
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al		PRINCE Social Security N	umber	6. Se	X	7. Age (in yrs. k	lest birthdey)	If Unde	er 1 Yea	ar If Unde	r 24 Hrs.	8. Date of Bi	irth		9. Birthple Country		or Foreign
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by Funerai		1 Never Marri			Armed 1 Ye If Yes,	Forces?	BI III 0,0		If Yes, sp				ecify Yes or N Rican, etc.)			k, White, et	c.	
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29c. License number

300 HOSPITAL DRIVE CHEVERLY

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State Registrar MARIO F- GOLLE
31. Dete filed (Month, Dey, Year)

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21215-0020	or all	2	1 ☑ Never Merr 3 ☐ Widowed	ied 2 Married 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date:	No		Yes, specify Cul ☐ Yes 2 No		Rican, etc.)	Specify	ck, White, e	lack
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	Puneral Funeral staly filled		9a. Certifier	1 Certifying Ph		TW STY			time, date end place,				RING MONTGO
	fo the Hospital within 24 hours a fo the Funeral completaly filled Medical Ce		(Check only one)	20 Medical Exam	niner: On the basis and manner	of examination	n and/or inv	estigation, in my	opinion, death occur	red at the time	, date end place,	and due to	the cause(s)
	To the lithin 2 to the comple		9b. Signature and	title of certifier	1/			29c. Licen	se number		29d. Date signe	ed (Month, D	Pay, Year)
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	3	3	0. Name and add		completed cause of	f death (Item 2	3a) (Type, F		n Street,	Baltin	nore. Ma	rvland	1 21201
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	Registrar	ļ	1 9 19	3 82 Pr	السير	4	20.	<u>;</u>					

12 13 1395 James & Hande

	_	G780 2/17/00 mend item 23a Decedent's Name (First, Mide	pt.11 2			rtificate (of D	eath		2. Date of D	Reg. No.	19	37887 3. Time of Death
ysician		Marian A.	Dixon El	on Dixon	Elliott					Month NOVEME	Day	Year 1999	2040 PM
Medical aminer	4.	Facility Name (If not institution	on, give street and i	number)			4b.	City, To		cation of Dea		y of Death	12040 PM
		1418 NOVA AVEN				T #11-d4V				EIGHTS			ORGES
al or		Social Security Number 577–72–2831	6. Sex 1 □ M 2 🕸 F		s. last birthday) 45 Yrs.	Months Da		Hours	Min.	8. Date of B	ley, Year)		place (Stete or Foreign ntry)
		sual Residence of Decedent			43				-	May 21	. 1954	Was	hington,D.(
3.		Da. State 10b. Count	•		Capit		- 1- A						10d. Inside City Limits
Director		Maryland Princ De. Street and Number	e George	S	Capit	tol Hei		S					1 Yes 2 No
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Funeral	1	1. Marital Status	12. Wes De	ecedent Ever in	U,S. 13.	Was Decedent If Yes, specify (0747 of Hisp		gin? (Spe	cify Yes or N	Unite	ce - Americ	can Indien,
		1 Never Married 2 Ma 3 Widowed 4 Divorce	mied 1 ☐ Yes	Forces? s 2 1 No Give Detes:		1 ☐ Yes 2 🛗		Mexican Specify:	, Puerto	Rican, etc.)		ick, White, _{fy:} Blac	
		15. Decede	nt's Education		16a. Dece	dent's Usuel Oc	ccupatio	on			16b. Kind of B	Business/In	dustry
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		12				Cashier				ann a second	Priv		
o Be	í	7. Father's Nama (First, Middla Walter Alvin					1				e, Maiden Sumai	me)	
Ĕ	•	9a. Informant's Name/Relation			19b. Maili	ng Address (St	reet an			Mae Mc	ber, City or Town	, Stata, Zir	o Code)
		Carolyn Dixon	-Cook/ Si	ster	1443	Souther	rn A	lve.	#30	l Oxon	Hill, M	lary1a	and 20745
	20	De. Method of Disposition 1 Disposition 2 Cremetion	3 Demoval from		cemetery, crei	osition (Name o	plece)			Date	20c. Location		
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100	2	Signature of Funeral Service	Licensee			2. Neme and Ad lexande				meral	Homes		
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	1	3a. Part f. Enter the disease, o shock, or heart failure. Lis	t only one cause or	each line.								1	Approximete Interval Between Onset and Death
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ORIGINAL

388 mark 888

MOV 3 6 1999

2:20

Yes 2 No

Director

Funeral

Completed

Be

23a or 72 hours after natural, or Hygiene. permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
important: If Item 27 is marked oth-any injury or other traumatic event

altimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner physicien end s the burial-transit Box 68760, Physician/Medical signed by the þ Records, Completed Vital Attending Physician: 8 Division of this. To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: All completely filled in by the fu death.

Raymond

Harry

DALEY,

Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Month Dev HARRY RAYMOND DALEY, SR. NOVEMBER 21, 1999 4a Facility Nama (II not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Months Days Hours 1 MM 2□ F 214-09-2610 84 SEPT. 25, 1915 PENNSYLVANIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 1330 Potomac Avenue 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No If Yes, Giva 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tailor Self Employed 10 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Herman Tilman Daley Gladys Ella Gorman 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosalie Curran/Daughter 11125 Eastwood Drive, Hagertown, Maryland 21742 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Rest Haven Cemetery Nov.23 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 21. Signature of Eunerel Service Licensee Lucion A. Flery 23a Part1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a. Ischemic Bowel, Anoresia,
Dua to (or as a consequence of): WearedeljiHEART Immediata Causa (Final 2 week diseasa or condition resulting in death) FAILURE, ARRYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Edl stage Kuly gifevil; Prostate CANCEL; Disease; Congesture Heat Failure. 24a. Wes en autopsy

25. Was casa referred to medical examiner? Hospital: Other: 45 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No t ☐ Yas 2 ☐ No 26. Place of Death (Check only one)

1 Yas 20 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 1 Netural 5 Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide

28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Yas 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier 162A Mg Eli'

4 ☐ Homicide

29a. Certifier (Check only one)

> 29c. License number 00022313

29d. Date signed (Month, Day, Year) 11-22-99

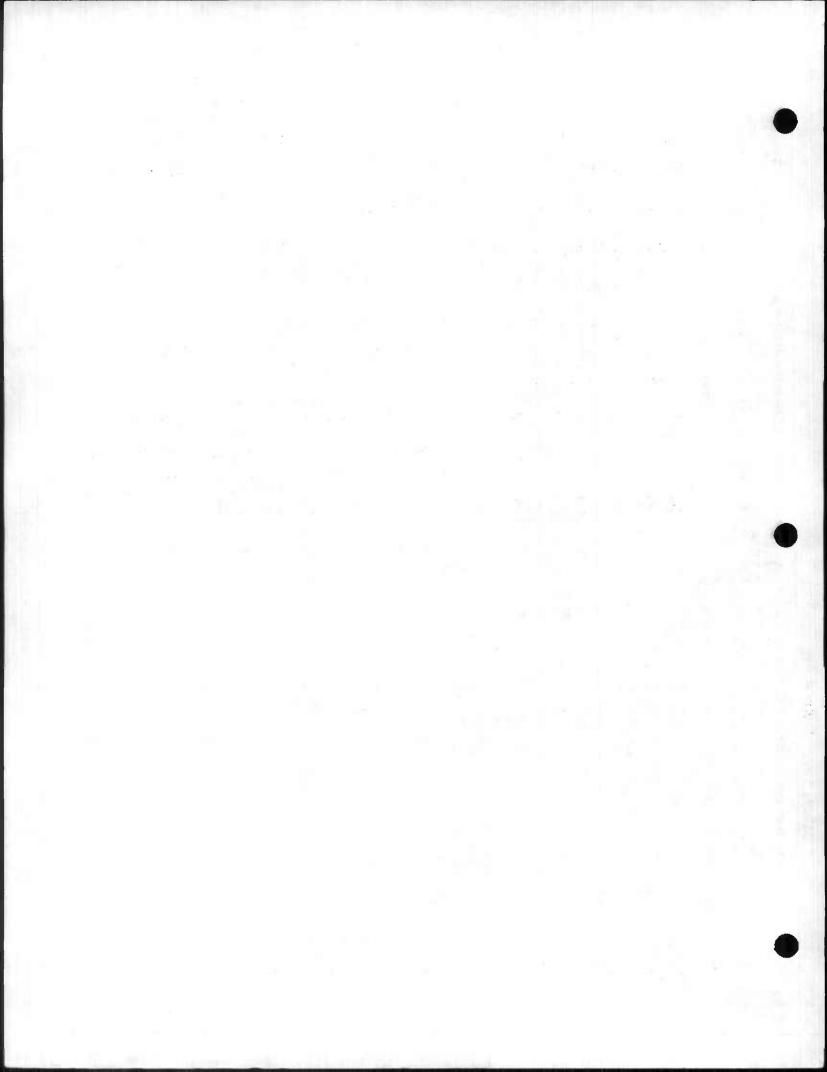
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) ITAGERS TOWN, Mg 21772

State Registrar

31. Date filed (Month, Day, Year)

NOV 2 3 1999

32. Hogistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedeni's Neme (First, Middle, Last) 2. Data of Death Day Worth Day Year VOVCMber 20 1999 **Physician** Virginia Lane Drake /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Euperal** Days 1 □ M 2 🗙 F Months Yrs. 82 Director Feb. 27, 1917 West Virginia 216-14-5061 Usual Residence of Decedent 10a. Sleta 10b. County 10c. City, Town or Location Show 10d. Inside City Umits 1 ☐ Yes 2 ☑ No Director Maryland Washington Williamsport 284-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 16136 Cloverton Lane 21795 USA 238 Items : 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, Whita, etc. 1 ☐ Never Merried 2 ☑ Merried altimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. Elementery/Secondary (0-12) College (1-dor 5+) Retail Clothing Sales 12 Sales Clerk permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, pages. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) William Henry McElroy Martha Alice Shupp 2 19a. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Tom F. Drake/Husband 16136 Cloverton Lane Williamsport, MD 21795 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Ramoval from Stata 4 Donation 5 Other (Specify) Smithsburg Crematory Nov 23, 1999 Smithsburg, Maryland 21. Signeture of Funeral Service License 22. Name and Address of Facility 425 S.Conococheague St. Williamsport,MD 21795 Osborne Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ear Examiner Due to (or as a consequence of): Examiner cor een,'c physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Virginia Lane Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? Completed complation of cause of death? 1 Yas 2 No 1 Yas 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 PER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? edical Certification: 28b. Time of 28d. Describe how injury occurred Attending 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident Director 6 Could not be determined To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of axaminetion and/or invastigetion, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) and mannar stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signetura end Iitla of certifian

State Registrar

DHMH 16 Rev 6/95

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HILLAVE. HAGERSTOWN.

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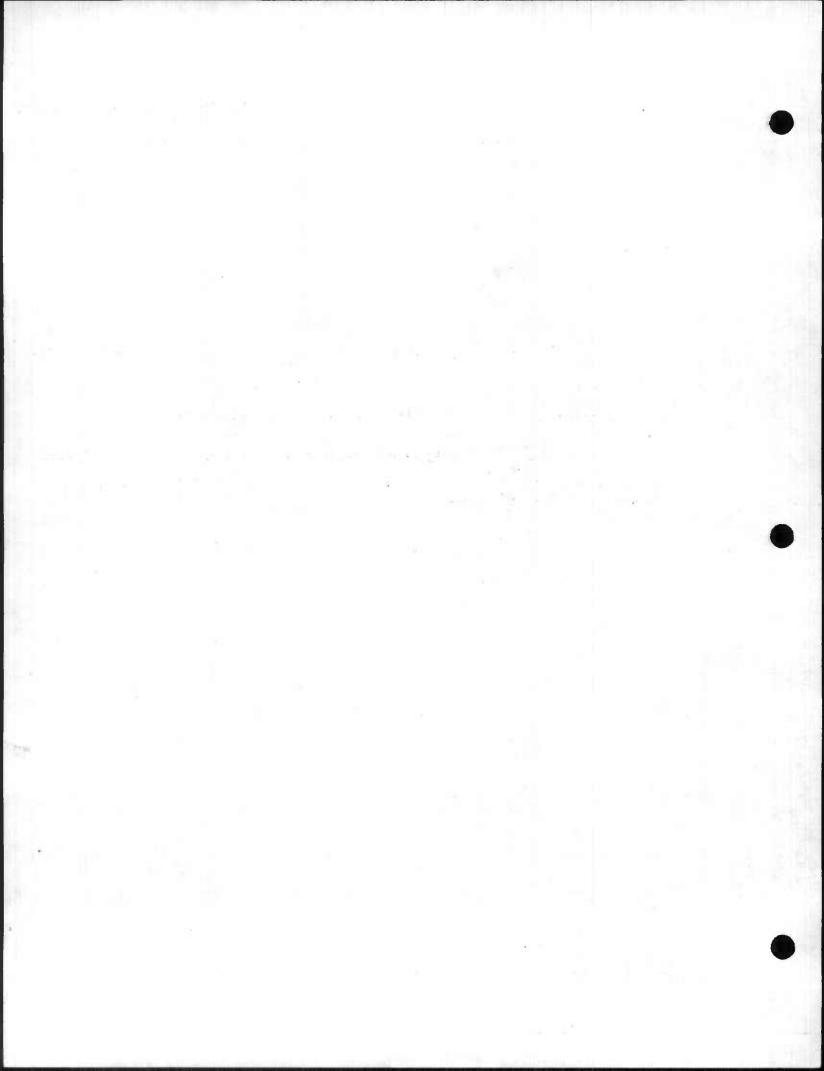
31. Date filed (Month, Day, Year)

304 Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

un

32. Registrer's Signature

Beneva



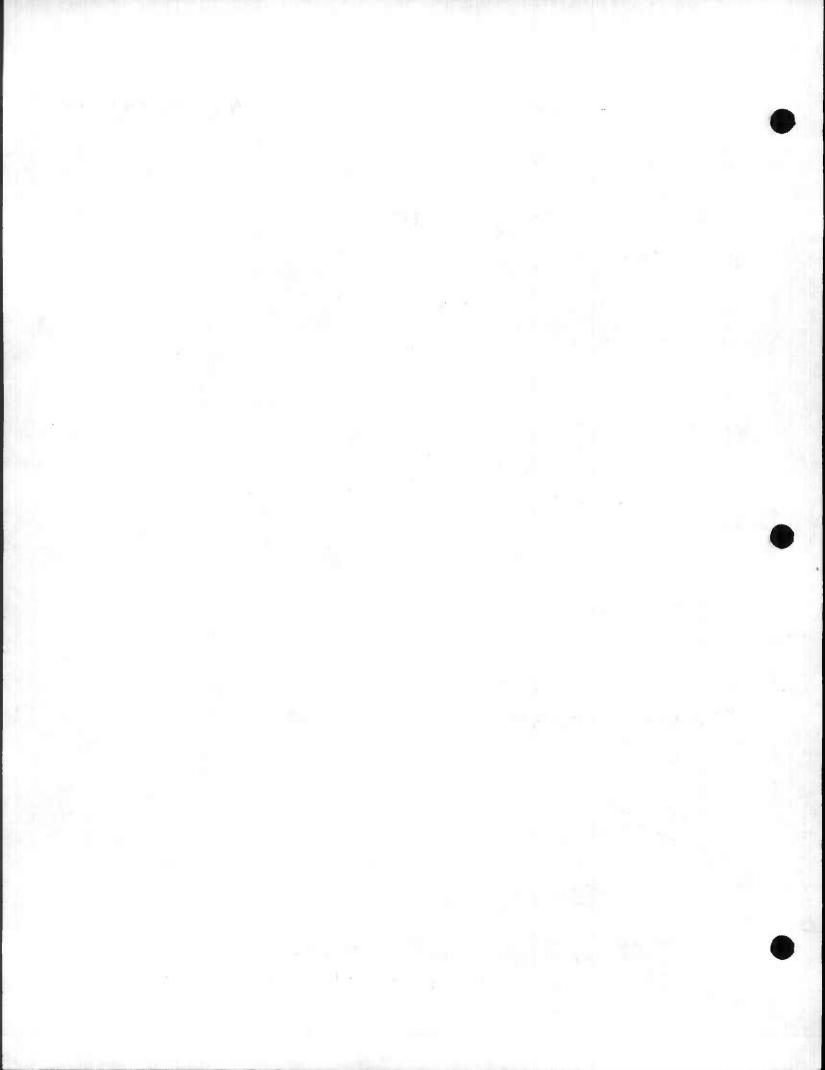
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State of Maryland / Department of Health and Mental Hygiene 99

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	Certificate of	Death	Re	g. No.	
lhinin	Decedent's Neme (First, Middle, Last)		2. Dete of Death Month	h Dey Yea	3. Time of Death
hysician /Medical	MILLIAM LEMIC INDAVE		Nov	19 199	
xaminer	A - 100 - 100 - A	4b. City, Town, or Lo	ocation of Deeth	4c. County of D	eeth
	WASHINGTON COUNTY HOSPITAL	HAGERSTO	WN	WASHIN	GTON
eral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8. Dete of Birth (Month, Day,	Year) 9.1	Birthplece (State or Foreign Country)
tor	219-20-2490 19M 2 F 71 Yrs. Marins Days		APRIL 19	9, 1928 M	ARYLAND
	Usuel Residence of Decedent				Lance as as as
1	10a. Stele 10b. County 10c. City, Town or Location				10d. Inside City Limits
9	MARYLAND WASHINGTON BOONSBORO				1 NYes 2 No
Directo	10e. Street and Number 10f. Zip Code		10	og. Citizen of What	Country?
		713		U.S.	Α.
Funeral	11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of If Yes, specify Cul	Hispanic Orlgin? (Speben, Mexican, Puerto	ecify Yes or No-		merican Indian,
	H Vac Give		,	Specific	
P	Year or Detes: KOREAN	o openy.		Specify: W.	HITE
Completed	15. Decedent's Education 16a. Decedent's Usuel Occu (Specify only highest grade completed) (Give kind of work done	upation e during most of worki	ina 1	16b. Kind of Busine	ss/Industry
aldo	Elementery/Secondery (0-12) College (1-4or 5+)	ed)			
00	10 YEARS CORRECTIONAL (OFFICER	S	STATE GOV	ERNMENT
Be	17. Father's Neme (First, Middle, Last)	18. Mother's Neme	e (First, Middle, M	feiden Sumeme)	
To	WILLIAM LEWIS DRAKE	ATHA GEN	EVIE NOR	RRIS ELLI	S
	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street	et end Number or Rurs	al Route Number,	City or Town, Stet	e, Zip Code)
	BETTY J. DRAKE/WIFE 108 NORTH MAIN	N STREET,	BOONSBOR	RO. MARYL	AND 21713
	20a. Method of Disposition 20b. Pleca of Disposition (Neme of camelery, cremetory or other plants)			20c. Location - City	
	1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) FAIRVIEW CEMETER:		00 VE	PEDVCUTTT	TO MADVI AND
	21. Signature of Funerel Service Licansee 22. Name end Addr				E, MARYLAND
Suc	P. O' Ungering.	. 70		NATIONAL .	
	2. BIBVER BIRTERS, OR.	RAL HOME B		-	
-	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heer feilure. List only one cause on each line.	ying, such es cardiec d	or respiretory erre	ost,	Approximete Interval Between Onset end Deeth
ın	/				Onset end Deedi
al er	Immediate Cause (Final disease or condition and the condition are within in death)	arelio	2		menut
	Due to (or as a consequence of):				
edical Examiner					1
E E	Sequentially list conditions, Due to (or es e consequenca of):				
<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.				
S	thet initiated events resulting in death) Last				
Medical Examir					
10	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause g	given in Pert I.	23b. Did tol	bacco use contrib	ute to the cause of death?
by Physician/R			12 Ye	a 2 No 3	Probably 4 Unknown
× F	seure emphysems				
			24a. Was an		lb. Wara autopsy tindings aveilable prior to
mpleted			perform	ned f	completion of cause of death?
Ē				-54	
			1□ Ye		1 Yes 2 No
8		26. Place of Deet	h (Check only one	9)	
10	1 Linpatient 212 ER/Outpatient 3Li DOA			nce 6 Other (S	Specify)
	27. Menner of Death 28a. Dete of Injury 28b. Time of 28c. Injury Williams 1 Injury 28c. Injury Williams 28c. Injury Williams 28c. Injury Williams 28c. Injury Williams 28c. Injury Williams 28c. Injury Williams 28c. Injury Williams 28c. Injury Williams 28c. Injury 28c. I		28d. Describe ho	w Injury occurred	
atk	2 Accident investigation M 1	Yes 2□No			
tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	9	28f. Location (Str. City or Town		r Rural Route Number,
Certification:	ounding, viv. (Opporty)				
edicai	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my and menner steted.	opinion, deeth occurr	red at the time, de	ete and place, and	due to the cause(s)
×		nse number	29	9d. Date signed (M	ionth, Dey, Year)
	DA F	2 =10		1-1	
	30 Name and address of person who combleted course of death ///or 1000 Time Paint)	2518	111,	120/99	
	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)	and D.		11. W	10-1
	21 Detailed (Month Day Year) 22 Spainter's Signature	une my	Eay 30	1116 1	laryunce
State	31. Dete filed (Month, Dey, Year) NOV 2 2 1999 32. Registrer's Signeture 9. Spork	41			
gistrar	MUV G & 1000	2/			

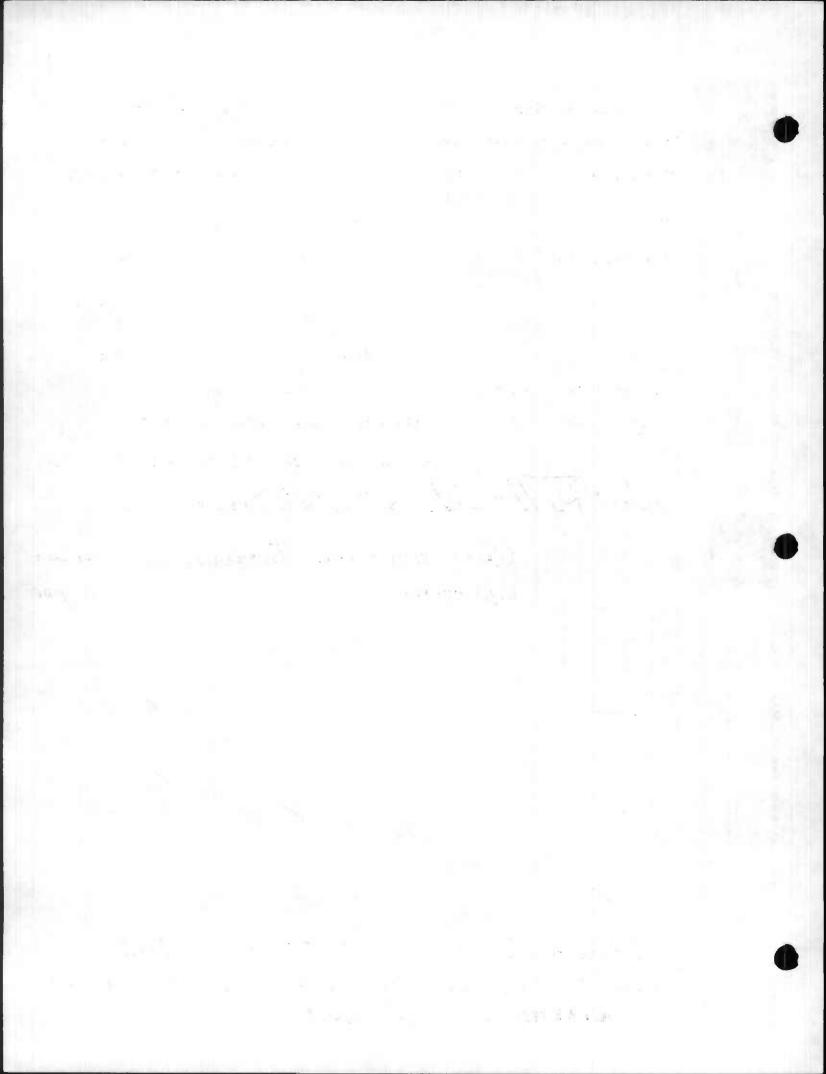
Drake, William



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State of Maryland / Department of Health and Mental Hygiene

				eriincaie	e of De	alli		1	Reg. No.	0	1001
	1. Decedent's Name (First, Middle, Las	st)					2	2. Dete of De Month	eth Dey	Year	3. Time of De
Physician '/Medical	William Fred	dlock DEBH	ERRY				1		20, 199		9:40
Examiner	4e Facility Neme (If not institution, give	street end number)			4b. C	City, Tow	m, or Loca	tion of Death	4c. County	of Death	
	Dennett Road Mand	or Nursing	Home			0a	klan	d		Garr	ett
Funeral Director	5. Sociel Security Number 6. Se 218-07-3817	ex 7. Age	(In yrs. last birthde	Months		Under 2 lours	Min.	Date of Bird (Month, Da	h y. Year) , 1910	9. Birthpi Coun Mary	lece (Stete or F try)
D	Usual Residence of Decedent										
72 hours effect death with the Maryland natural; or frame 23a or 28a-f show deal Examiner must be northed at sted by Funeral Director	10a. Stete 10b. County		10c. City, Town or		1					10	0d. Inside City 1 ☐ Yes 2
or 28a-f si be no crited	MD Garre	ett		Oaklan				T	10g. Citizen of	What Coun	tru?
				101. Zip		_					ч
iter death virter from 234 siner must	110 DeBerry Lane	e 12. Wes Decedent Ev	vos in II C 1	3 Mas Dood	21550		in? (Cana	h. Van ar Na		USA ce - Americ	en Indien
Trem Tun	11. Marital Status	Armed Forces?		Was DecededIf Yes, specience	eify Cuben, N	Aexicen,	Puerto Ri	can, etc.)	Ble	ck, White,	
by F		1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:)	1 ☐ Yes 2	No S	pecify:			Specif		
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C = 0 -	Maxine F. DeBerr	ry/wire	20b. Place of Dis			ne,	Uakl		d. 2155		. 01.1.
	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removel from Stata	cemetery, o	remetory or ot	ther place)			Dete	20c. Location	- City or 10	wn, Stete
reges nent of l ant: If Ite ury or o	4 Donetion 5 Other (Specify		Garrett	Co. Me	m. Ga:	rden	s 11	/22/99	0akl	and,	Marylar
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Adam Dewitt

State of Maryland / Department of Health, and Mental Hygiene 28A-F PER MEO Certificate of Death AMEND ITEMS: #23 PART I, 27,

99 Reg. No.

Physician	
/Medical	
Examiner	
Examinica	

Directo

Funeral

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Completed

Be

Examiner

Physician/Medical

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Be Completed

Medical Certification: To

11

DERECK ADAM DeWITT

1. Decedent's Neme (First, Middle, Last)

2. Date of Death Month 13, 3. Time of Death

10d. Inside City Limits

4e Facility Name (If not institution, give street and number)

November 4b. City, Town, or Location of Death

1999 10:12 A.M.

Funeral Director

288-1

8 238

Home

8

I Hygiena.

Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked off

nt of Health a iff Item 27 is or other tra

Department of important: if any injury or once.

filed within 72 hours after

21215-0020

Baltimore, Maryland

5. Social Security Number 1X M 2 F 214-15-1133

5200 Block Hutton Road Oakland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Days Hours Months 17 Yrs.

Garrett 9. Birthplace (Stata or Foreign

Usuel Residence of Decedent 10a. Stete 10b. County

10c. City, Town or Location GARRETT

College (1-4or 5+)

8. Date of Birth (Month, Day, Year) AUG 22, 1982 MARYLAND

MD

OAKLAND

1 ☐ Yes 2 No

10e. Street and Number

512 GARRETT ROAD

21550

10f. Zip Code

10a. Citizen of What Country? USA

4c. County of Death

11 Merital Stetus

1 Never Merried 2 Married 3 Widowed 4 Divorced

12. Wes Decedent Ever in U,S. Armed Forces? I ☐ Yes 2 No If Yes, Give Year or Dates:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

Black, White, etc. Specify: WHITE

14. Race - American Indian,

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12)

STUDENT

 Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

SCHOOL

17. Father's Name (First Middle Last)

MICHAEL JAY DeWITT 18 Mother's Name (First, Middle, Maiden Sumame) NAOMI JANE WEEKS

Date

19e. Informent's Neme/Reletionship (Type, Print)

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 512 GARRETT ROAD OAKLAND, MD 21550

NAOMI DeWITT - MOTHER

20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 20b. Plece of Disposition (Nama of cemetery, cremetory or other place)

20c. Location - City or Town, Stete

4 ☐ Donetion 5 ☐ Other (Specify)

PLEASANT VALLEY CEMETERY 11/16/99 OAKLAND, MARYLAND

22. Name end Address of Facility

ire of Funeral Service Licensee 23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

M00167

DURST FUNERAL HOME - OAKLAND, MD 21550

P.O. BOX 243

Physician /Medical Examiner

pug

the

88 950

page 2 should

filled in by

completely

this certificate has

al or Attending Physician: The safer death.

In Director: After this certificated in by the funeral director, pr

To the Hospital owithin 24 hours a To the Funeral D

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

of Vital

Division

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition rasulting in death)

CONTACT GUNSHOT WOUND OF THE HEAD

Dua to (or as e consequence of):

Due to (or es e consequence of):

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an eutopsy

24b. Were autopsy findings available prior to completion of cause of death?

Approximete Interval Betw Onset and Death

1 Yes 2 No 1 ☐ Yes 2 ☐ No

25. Was case referred to medicat Yes 2□ No

27. Manner of Death

1 Neturet

2 Accident

3 ☐ Sulcide

4 Homicide

5 Pending invastigation

6 X Could not be dataminad

NOV 1 5 1999

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Deta of Injury (Month, Dey Year) FOUND: 99

28b. Time of A FOUND:

М

28c. Injury at Work? 1 XYas 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) at Scene 28d. Describe how injury occurred SUBJECT FOUND SHOT

26. Place of Death (Check only one)

111 Penn Street, Baltimore, Maryland 21201

281. Location (Street and Number or Flyral Floure Number City or Town, Stete) 5 2 0 2 HUTTON ROAD OAKLAND, MARYLAND

29e, Certifier (Check only one)

Y=TG=99 | 5-UND: M | 10
Plece of Injury - At home, ferm, street, factory, office building atc. (Specify)
FOUND: WOODLAND 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature end title of certifier,

29c. License number C.C.M.E.

29d. Date signed (Month, Day, Year) November 14, 1999

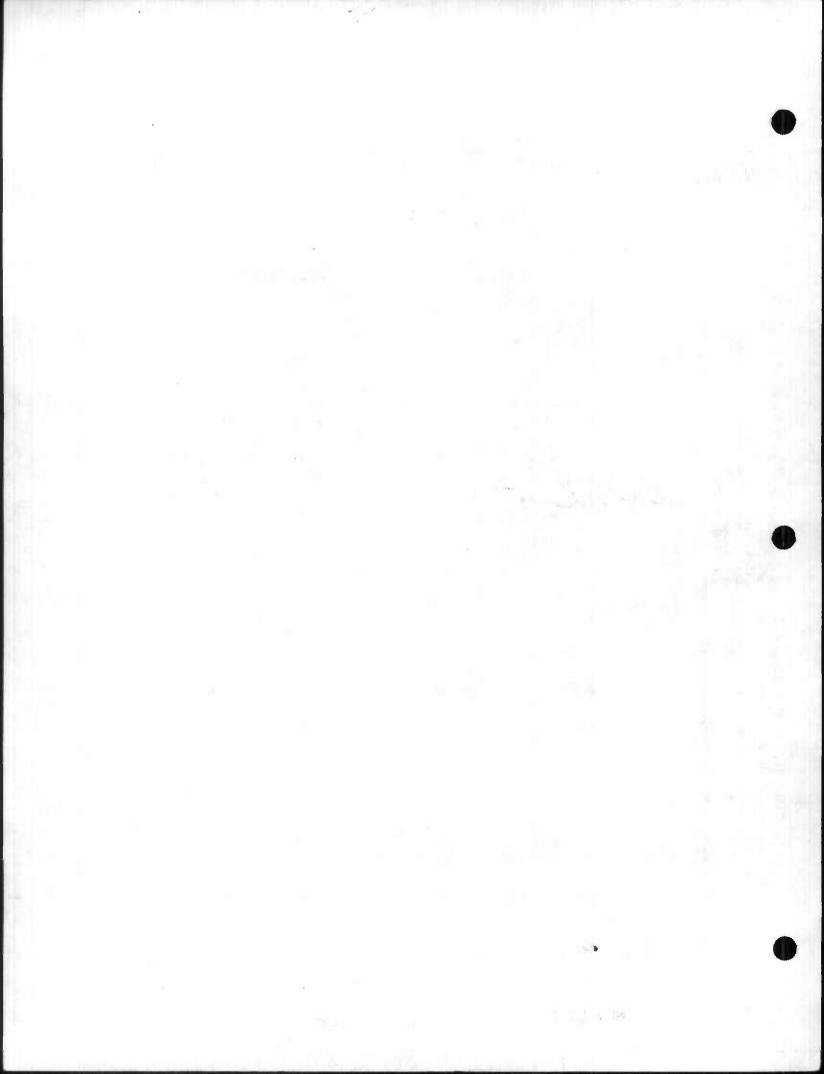
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DREDRUM 31. Dete filed (Month, Day, Year)

Koror Dun. 32. Registrer's Signeture

State Registrar

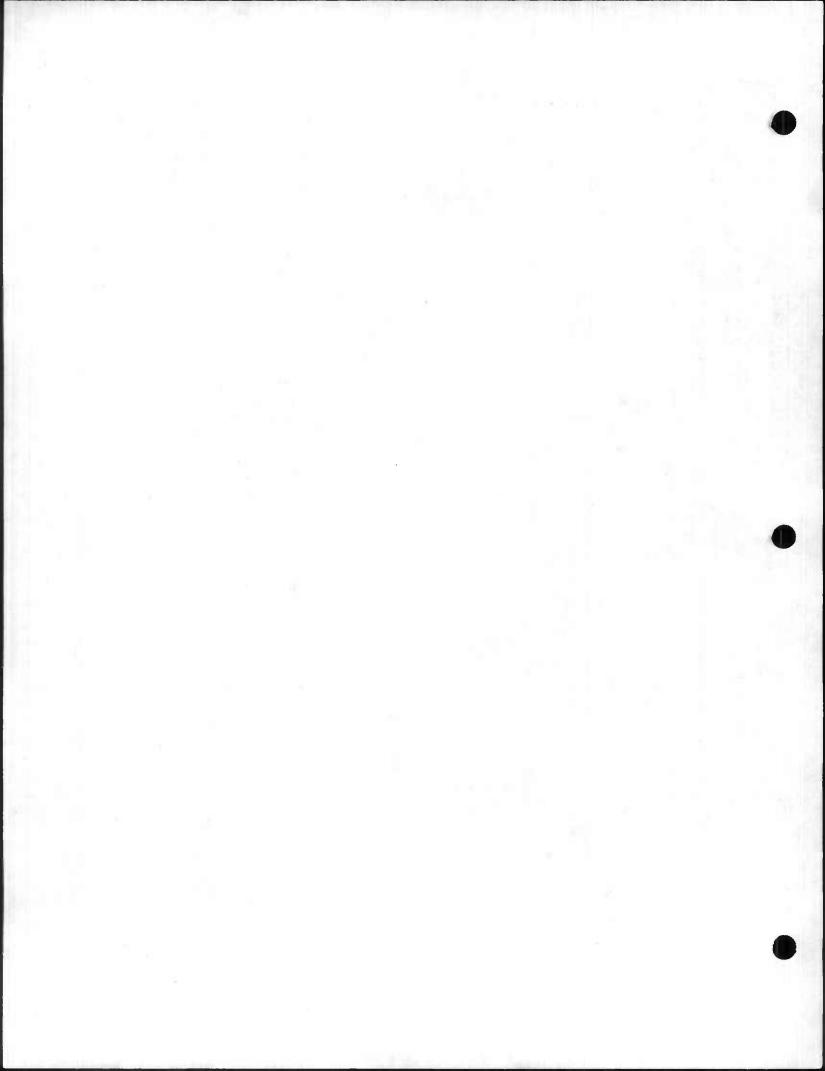
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 11, 1999 4:18 P.M. Dagenhart November Max A. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Months 1⊠M 2□F Yrs 88 Director 214-09-9534 SEPT. 18, 1911 MARYLAND Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. fnslde City Limits r then "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at 1 Ves 2 □ No Directo MARYLAND WASHINGTON KEEDYSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 94 SOUTH MAIN STREET 21756 U.S.A.

14. Race - American Indian,
Bleck, White, etc. Funeral deeth 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mentel Hygiene. Important: if them 27 Is merked other than "natural; or itsn eny Injury or other traumatic event, the Hedical Estimations. 1 X Yas 2 No 1942— If Yes, Giva Year or Dates: 1945 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) STONE & BRICK MASON CONSTRUCTION 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be URNER S. DAGENHART KATHERINE POFFENBERGER 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 94 S. MAIN ST., KEEDYSVILLE, KATHY HOFFMAN/DAUGHTER MD 21756 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriaf 2 M Cremation 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) SMITHSBURG CREMATORY 11/12/99 SMITHSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean 21713 Boonsboro, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete fritarval Batween Onset and Deeth Physician /Medical Scheroderna Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Aspiration The lew requires that the death certificate be executed attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by to detach Periphen 1 Yas 2 No 3 Probably 4 Unknown à 24b. Wera autopsy tindings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificata director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No Certification: To this After this funeral 27. Magner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attanding Pt within 24 hours after deeth. To the Funeral Director: Aftar it completely filled in by the funera 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick S, 300 Grissum MM anes 32. Registrer's Signature 31. Data filed (Month, Day, Year) State NOV 1 5 1999 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent'a Nama (First, Middla, Last) Date of Death November 14, 1999 QUINCY ALBERT FAISON 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death LANHAM PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL ff Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplaca (Stata or Foraign-Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months 10XM 20 F 244-86-3854 48 June 18, 1951 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. Stata 10b. County t 0d. Inside City Limits 1 X Yas 2 □ No Maryland Prince George's Capitol Heights 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 20743 U.S.A. 720 Carrington Place 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian, 11. Marital Status Bleck, White, atc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: **Black** 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 11th 17. Father's Nama (First, Middla, Last) 18. Mother'a Nama (First, Middla, Maiden Sumama) Olcie Faison Estella Carr 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Ralationship (Type, Print) Glenda Faison/Wife 720 Carrington Place, Capitol Heigts, Maryland 20743 20b. Place of Disposition (Nama of cematary, crematory or othar place) Data 11/20 1999 20e. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Nemoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) New Kirk Chapel Cemetery Wallace, North Carolina 22. Name and Addrass of Fecility
J.B. JENKINS FUNERAL HOME 21. Signature of Funaral Sarvice Licensee 7474 Landover Road, Landover, Maryland 20785 ancu 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure: "List only one cause on each line." Approximata Intarval Batween Onset and Death Immediata Causa (Final disease or condition rasulting in death) CARDLO PULMONARY 24 Hours Due to (or as a consequence of): 24 Hours SEPSIS Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): KIDNEY FOOLUNE Dua to (or as a consequence of): DIABETES moziTU3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dfd tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown STAGE RENAL DISEASE 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? UNCONTROLLED HYPCHTENSON DIABOTIC NOPHROPPATHY 1 Yas 2 10 100 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medicat axaminer?

1 Yes 2 No 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner sician and buriel-transit physician s the buriel Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r 28a-t show

r than "natural", or items 23s or the Medical Examiner must be

fand 2 should be fi

Baltimore, Pages 1

If them 27 is

Directo

Funeral

by

Completed

Be

Physici þ 10

an/Medical Completed

Records, P.O. Division of Vital To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

2 Accident 6 Could not be detarmined 3 Suicide 4 Homicide

1 DNatural

29a. Certifier (Check only one)

28a. Data of Injury (Month, Day Year) 5 Pending invastigation

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28b. Time of

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and titla of certifier Ruso con alum, into 29c. License number D44885-mo 29d. Data signed (Month, Dey, Year)

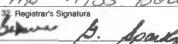
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

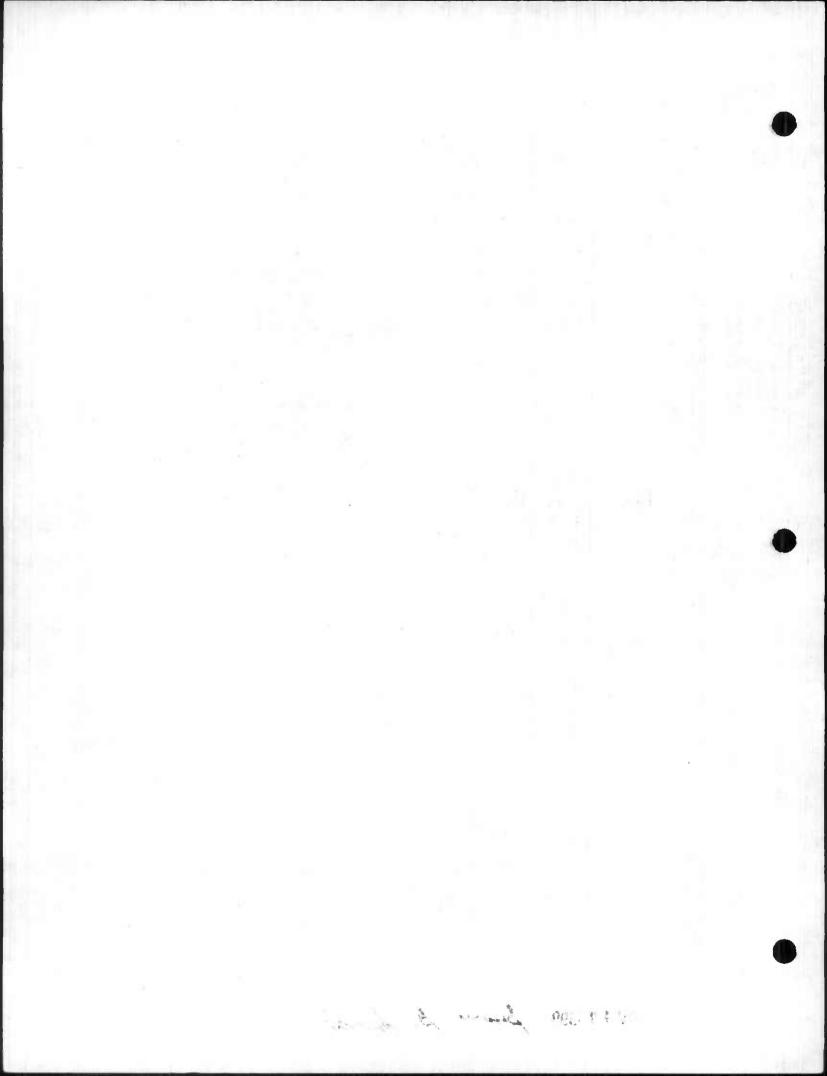
ROSCOG AD Ams mo 7735 31. Data filed (Month, Day, Year)

BULL PINT DR. GREWBUT, MD

Registrar

NOV 17 1999





Funeral Director permit. Peges 1 end 2 should be filed within 72 hours after death with the Merylend Depertment of Health end Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24-hours after death.

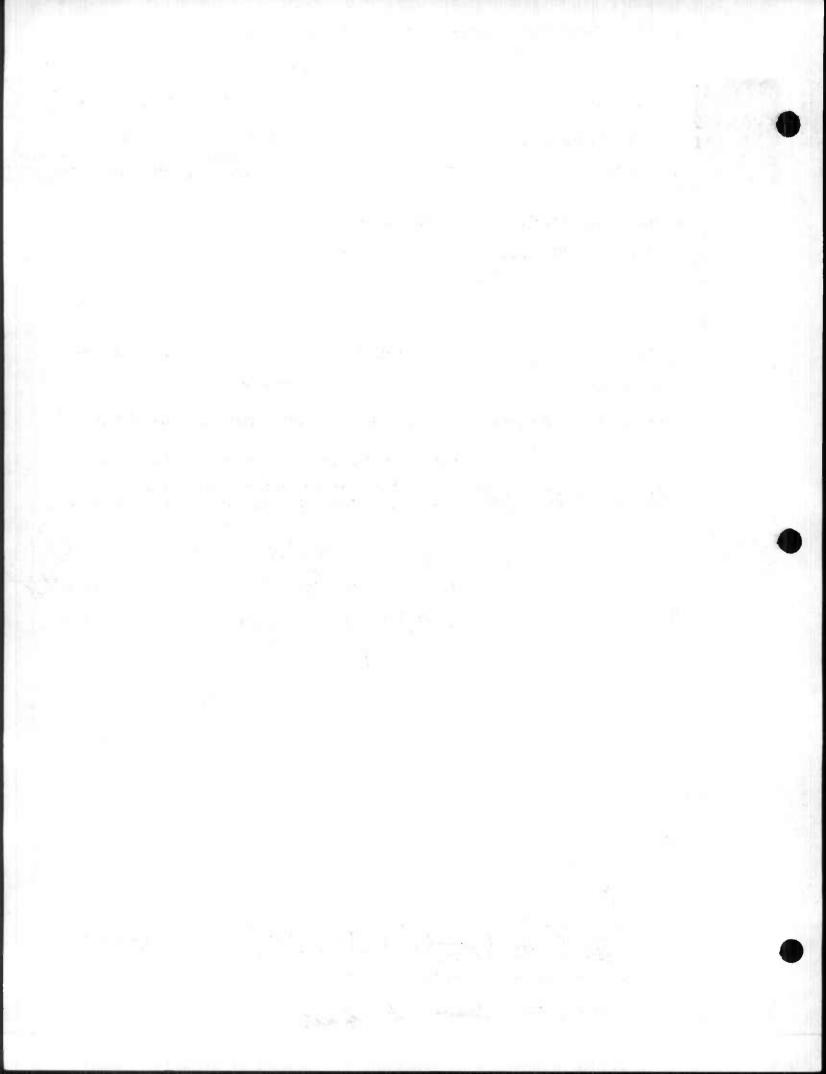
To the Funeral Director: After this certificate has been signed by the attending physicien and completaly filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

NAME: THELMA FROME

State Registrar

. Decedent's Neme (First, Middle	, Last)				2. Dete of Deeth			3. Time of Deeth
Thelma Mari	e Frome				OCTOBER	30, 1	999	2:05PM
e. Fecility Neme (If not institution	give street and number)			4b. City, Town, or	Location of Deeth	4c. County	of Death	
St. Mary's Ho	spital			Leonardt	own	St.	Mar	y's
. Societ Sacurity Number	6. Sax 7. Age (In yrs.	last birthday)	If Undar 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Dete of Birth	Vonel	9. Birth	pleca (State or Forai
194-16-5595 Usual Residence of Decedent	1□ M 2\\ F 76	5 Yrs.	WOMEN'S Days	Hours Will.	8. Dete of Birth (Month, Day, October 3	, 1923	Penn	sylvania
0e. State 10b. County Maryland St.		y, Town or Lo	cation					10d. Inside City Limit 1 ☐ Yes 2 💢 N
0e. Street end Number	. Lary 5	CIRCITA	10f. Zip Code		10	g. Citizen of \	Whet Cou	intry?
28881 Lockes	Hill Road		206	59		U.S.	Α.	
1. Maritel Status	12. Was Decedent Ever in U	,S. 13.	Wes Decedent of H		pecify Yas or No-			can Indien,
1 Nevar Married 2 Marri 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		If Yes, specify Cub 1 ☐ Yes 2 🛣 No	en, Mexican, Puerl Specify:	o Rican, etc.)	Specify Specify	ck, White,	hite
X 15. Decadent		16e. Dece	dent's Usuel Occup	ation	1	6b. Kind of B		
(Specify only highes	t grade complated)	(Give	kind of work done DO NOT use retire	during most of wor	rking	OD. IKING OF D	a sii ta sarii	iodotty
Elementery/Secondary (0-12) 8th	Cotlege (1-4or 5+)		otionist		C	Ounty	GOVA	rnment
7. Fether's Neme (First, Middle,	ast)	, ARCCC	ACTOLITY C	18. Mother's Nar	ne (First, Middla, M			
Raymond Knott					ockhart			
19e. Informent's Neme/Relationsi	nip (Type, Print)	19h Maiii	na Address /Street		ural Route Number,	City or Town	State 7	in Code)
Patricia Cross			-		icsville,			
Oa. Method of Disposition	, , ,		sition (Name of	, rechall		Oc. Location		
1 ☐ Buriat 2 ☐ Crametion	3 ☐ Removel from Stete	emetery, crei	matory or other pla			J. LOUGHOTT	Ony Of 1	Jim proto
4 □ Donetion 5 □ Other (S _k	· · · · · · · · · · · · · · · · · · ·		an Cremator	-	11/3/99 A	ulexandr	ia, V	irginia
21. Signeture of Funarel Sarvice I	icensae		2. Name and Addra		on Fanore	1 Homo	D	7\
To about 9	Turi Vactoria	4	Mattingie	270 Too	er Funera	Marril Marril	and.	20650
23a. Part 1. Enter the disaasa, of	complications that caused the deal	Do not an	tar tha moda of dyli	ng, such as cardia	or raspiratory arra	st,	anu	Approximate
shock, or heart feilure. List	willy one cause on each line.		0	-	00		1	Intarvet Between Onset and Deeth
mmediete Cause (Final	(Va. V.	-0-	Vana and	and s	14.11			6 11
disaase or condition esulting in daath)	· Caran	gyn	Muria	y a	envie		-	NKI
	Due to (o	N a consec	quence of):	6-1				mark
17	· b carrie	ons	may	CACO			-	many
Sequentielly list conditions, feny, leeding to immadiete ause. Enter Underlying Ceuse (Diseese or injury	. (Var	ras a consec	quence of):	Lun	9			245.
het initieted events esulting in daath) Last	Due to (o	r as a consec	(uence of)		./			1
	d		/		/			0
	110 Ali							
art II. Other significant conditio	ns contributing to death but not res	ulting In the u	nderlying cause giv	ven in Pert I.	23b. Did tot	ecco use co	ntribute 1	to the cause of deet
					12X0	8 2□ No	3 □ Pro	obably 4 Unknown
					24e. Was en perform		a	Vere eutopsy finding vallable prior to ompletion of cause f deeth?
					1 □ Yas	s 2 No	1	☐ Yas 2☐ No
5. Wes case referred to medical				26. Place of De-	ath (Check only one		1	
examiner? 1 ☐ Yes 2 ☐ Vo	Hospitet: 1 ☐ Inpatient 2 🗹	R/Outpatie	nt 3 DOA Oth	ner:	lome 5 ☐ Residar		ar /Snee	ihe)
7. Menner of Deeth	28e. Dete of Injury	28b. Time o	f 28c. Inju	y et	28d. Describe hor		. ,	"7/
1 Naturet 5 Pending	(Month, Day Year)	Injury	Wo	rk? Yas 2 □ No		- 10		
3 ☐ Sutcide 6 ☐ Could n	ot be 28e. Pleca of Injury - At ho				28f. Location (Str.	eet end Numi	ber or Rui	ral Route Number,
4 Homicide	building, etc. (Specify	y)	•		City or Town,	STATE)		
	Physicien: To the best of my kno examiner: On the basis of examine and menner steted.							
			29c. Licens	se number	Q 29	d. Dete signe	(Month	Dey, Year)
(Check only Medical I	Jan Lan	-M) 1)	110041		10%	3/1	7 /
9b. Signeture end title of certifier 0. Name end eddress of person of	no completed cause of death Grein			0041		10/	34	
(Check only one) 9b. Signeture end title of certifier			Print) 0. 20636	0041		10/	34	
9b. Signeture end title of certifier 0. Name end eddress of person of		OOD, MI		0041		10/	34	



Physician /Medical Examiner The law requires that the death certificate be executed pue Box 68760, attending physiclan detached for u P.0. signed by t Division of Vital Records, certificate I or Attending Physician: after death. Director: After this certifica the in by To the Hospital within 24 hours a To the Funeral D complately filled in

Mary

enwick,

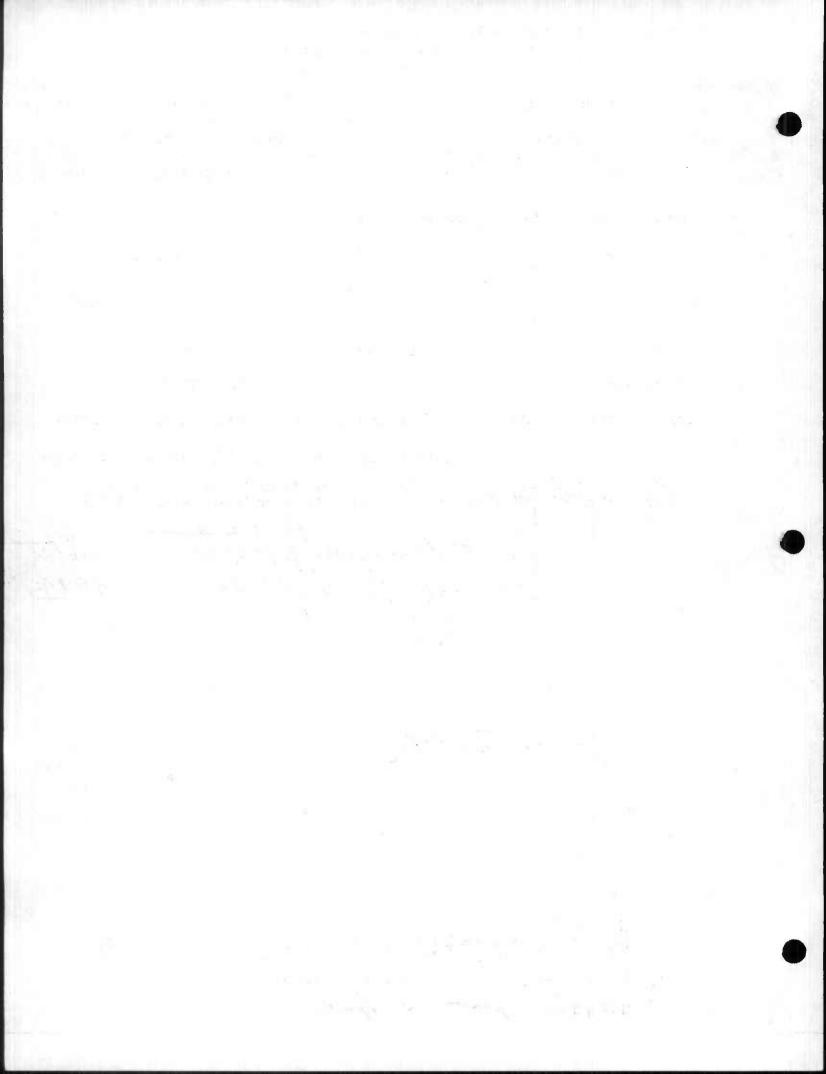
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 06 Yeer 1999 10:10am Mary Ruth Fenwick /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M a F Days 214-58-2260 Yrs 86 Director Maryland September 11, 1913 Usual Residence of Deceden 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 Yes ZNo Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23s 21633 Liberty Street 20653 U.S.A. Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 15. Decadent's Education (Specify only highest grade com 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed Pages 1 end 2 should be filed within nent of Health and Mental Hygisne. Int: If Item 27 is marked other then ary or other traumatic event, traille. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald Fenwick Mamie Elizabeth Tonev 2 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Goldring / Niece 21356 Lexington Drive, Great Mills, Maryland 20634 20a. Method of Disposition

1 □ Burlai 2 □ Cremation 3 □ Removal from State 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or Our Lady's Cemetery 11/11/99 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. araine P.O. Box 270, Leonardtown, Maryland 20650 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as guirdiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai Due to (dr. as a gonsequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24e. Was en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? NSA. 2 No 2□ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 44 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending 1 Natural 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifies Medical 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and pleted cause of death (Item 23a) (Type, Pfint) Hollywood, Maryland 20636 Patrick Darboe, MD 31. Date filed (Mohr) Day, Year 32. Registrer's Signature State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month **Physician** MARY HIGDON FORD November 16, 1999 2:30 PM /Medical 4e. Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WASHINGTON BOONSBORO 7745 OLD NATIONAL PIKE | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAX | 7, 1921 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpiace (Stata or Foreign Country) **Funeral** 1 □ M 2 1 F Yrs. 78 Director 577-24-4984 VIRĞINIA Usuei Residence of Dacedent with the Maryland 10a. State 10c. City, Town or Location 10b. County t0d. Inside City Limits 28a-f show ral', or items 23s or 28s-f shore Examiner must be notified at 1 ☐ Yes 2 No Directo BOONSBORO MARYLAND WASHINGTON 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? permit. Pagas 1 and 2 should be filed within 72 hours aftar death v Department of Haelth and Mental Hyglane. Important: If item 27 is marked other than "natural", or items 23a shy hjury or other traumatic event, the Medical Experient must. and. 7745 OLD NATIONAL PIKE 21713 U.S.A. Funeral 14. Race - Amarican indian, Bieck, White, etc. 11. Meritai Status 12. Was Decedant Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Etementary/Secondery (0-12) College (1-4or 5+) SECRETARY ENGINEERING COMPANY 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be FRANK (UMN) HIGDON CORNELIA NELLIE PEARL KIDD P 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) JAMES A. FORD/SON 7745 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 21713 20b. Piece of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BOONSBORO CEMETERY 11/19/99 BOONSBORO, MARYLAND 21. Signeture of Funaral Service Licensee 22. Name end Address of Fecility 7606 Old National Pike Dest (1. P. Steven Danfelt Jr. BAST FUNERAL HOME Boonsboro, Maryland 21713 23e. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or haart failure. List only one cause on each line. Approximete intervei Batw Physiclan immediate Ceuse (Finel disease or condition resulting in death) /Medical Arteriosclerotic Cardio Vascular Disease years Examiner Due to (or as a consequence of): Examine Tha law requires that tha daath cartificata be executed physiclan and s tha burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es e consequence of) attending pl signed by the a d be detached f Part ii. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 N Yes 2 No 3 Probably 4 Unknown Bipolar Disorder þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Gastroenteritis page 2 s has cartificata 1 ☐ Yes XXNo 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours aftar death. Funeral Director: Aftar this cartifica staly filled in by the funeral director, i Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospitei: Other: 4 Nursing Home 5 X Residence 8 Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? 1 K Naturet 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) end menner steted. 29e. Certifier To the Hosp within 24 hou To the Fune complately fil edical 29b. Signeture and title of certifler 29c. Licansa number 29d. Data signed (Month, Dey, Year) DO1062 dwarf a L November 17, 1999 30. Neme end address of person who completed cause of deeth (item 23e) (Type, Print) 217 W. Washington St. Hagerstown, MD 21740 Dr. Edward W. Ditto. III

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Dey, Year)

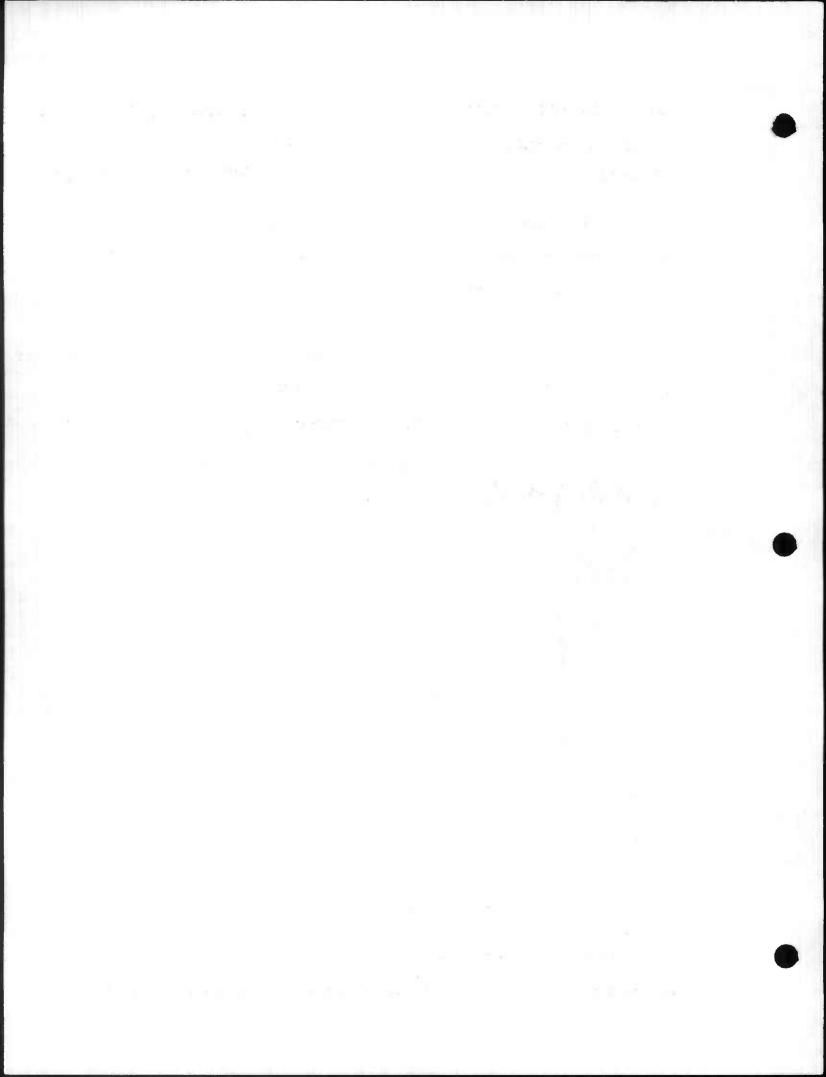
NOV 18

1999

32. Registrer's Signetura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Joseph Conrad Filsinger November 11 1999 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Greater Baltimore Medical Center Towson
If Under 24 Hrs.
Hours Min. Baltimore If Under 1 Year Birthplece (State or Foreign Country) Funeral Months Deys 1⊠M 2□ F 215-20-7522 75 Yrs. **Director** Nov. 1, 1924 Maryland Usuel Residence of Decadent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Washington County Hagerstown 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 20326 Jefferson Boulevard 21742 U.S.A. Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 1 X Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 25 Married 1 ☐ Yes 2 X No Specify White þ 3 Widowed 4 Divorced Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4 or 5+) President Wholesale Millwork Co. 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Conrad Lawrence Filsinger Julia Amanda Roe 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Velma Naomi Filsinger/Wife 20326 Jefferson Boulevard, Hagerstown, MD 21742 20b. Place of Disposition (Neme of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Nov.15 Hagerstown, Maryland 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility Douglas A. Fiery Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or hear dailure. List only one ceuse on each line. 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Onset end Deeth **Physician** RENAL FAILURE tmmediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e conseguence of) Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

— CARDIAC ARRIVATION IAS 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ ENCEPHALOPATHY Be Completed 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? RESPIRATORY FAILURE 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27. Menne of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner steted. edicai 29a. Certifier 29b. Signeture and title of pertifier 29c. License number D/Z73Z 29d. Date signed (Month, Day, Year) who completed cause of deeth (Item 23e) (Type, Print) FAIRMOUNT AVE BALTO DI) 21286 BEDON 515 31. Dete filed (Month, Dey, Year) NOV 1 6 1999 32. Registrar's Signature State Registrar

28a-f show

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items 23a

marked other than

Important: if item 27 any injury or other to

Box 68760

P.O.

Records,

Division of Vital

Hospital or Attending Physician:

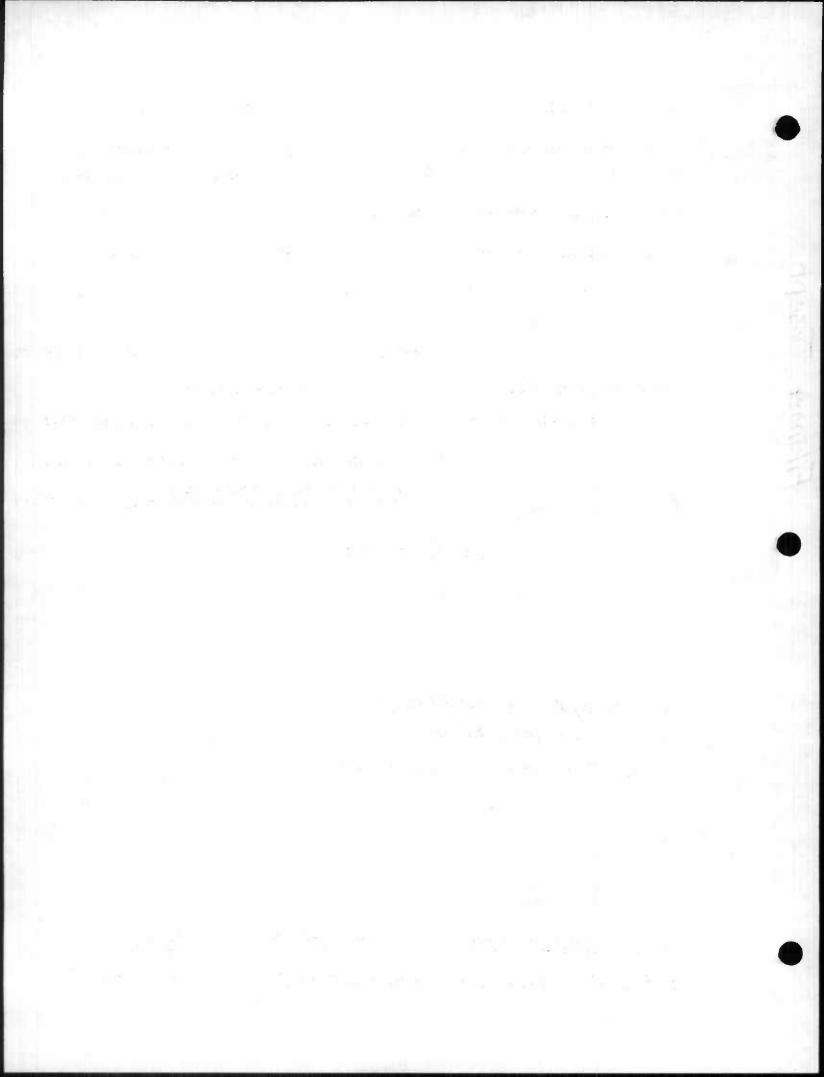
After

illed in by

s efter death.

To the Hospital of within 24 hours of To the Funeral Completely filled.

end Mental Hygiene.



Piease Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Deeth **Physician** LILLIE GATTISON 12:06 Pm NOVEMBER 1999 /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CENTER HARBOR BALTIMORE Hours Min. B. Data of Birth Month, Day, Year, 1921 SOUTH CAROLINA If Under 1 Yaar 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2\ F 77 Yrs. 577-56-5673 Director Usual Residence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 No MD ANNE ARUNDEL GLEN BURNIE Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 21061 UNITED STATES 6521 CEDAR FURNANCE CIRCLE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1X Yes 2 No If Yas, Give 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specity: BLACK à 3XXWidowed 4 ☐ Divorced Year or Datas: Completed 18a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) parmit. Pages 1 and 2 should be filed will Department of Heelth and Mentel Hygiena Important: If Item 27 Is marked other tha eny Injury or other traumatic event, the page. UNEMPLOYED 0 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be BEN WILLIAMS MARIA WATKINS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) CARRIE MULDROW / DAUGHTER 6521 CEDAR FURNANCE CIR.GLEN BURNIE, MD 21061 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 11-17-99 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 22. Nama and Address of Facility Dudley Funeral Home 3200 WOE.M. DUDLEY Rhode Island Ave. Mt.Rainier, MD 23a. Part T. Enter the disease or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediete Cause (Final disease or condition rasulting in death) /Medical Myocardial Interation Acuto minutes Examiner Due to (or es a consequence of) Examine attending physician and for use as the buriel-transit certificate be assecuted Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. edical Due to (or es a consequance of): Physician/M P.0. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Ves 2 No 3 Probably 4 Unknown Records. þ been si 24b. Ware autopsy lindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed certificete has 1 Yas 3 No 1 ☐ Yas 2 ☐ No Division of Vitai 8 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this edical Certification: 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred a of Attending P setter deeth. I Director: After to d in by the funeri 1 Netural 2 Accident 5 Pending invastigation 1 Yas 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura and titla of certifier (M.D) A 37 NOVEMBER AS244 1614 DEA 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) Baltimore South 21225 Hanover Street MD HTUT . 3001 31. Date filed (Month, Day, Year) 32 Registrer's Signetura State NOV 1 5 1999 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		EMS: #23A, 27, 28A-F PER MEO G784 7-3-00 WR Certificate of Death 1. Decedent's Name (First, Middle, Last)								
Physician	Theodore Fr	ancis Gray	November 26, 1999 5:16 PM							
/Medical Examiner	4a Facility Nama (If not institution, giva	straat and number)			4b. City, Town, or					
	Prince Georges (eneral Hospit	al		Cheverl	±	Prince	e Georges		
Funeral	5. Social Security Number 6. Sec	THE ACT OF		If Under 1 Y		(Month, Da	h y, Year)	Birthplace (Stata or Foreig Country)		
Director	378-84-0249	62 AM 201	Yrs.			August .	17, 1937	Washington, DC		
ž	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. tnslde City Limi		
or or	Maryland Prince Ge	orgos	ort Wa	chinat.	200			1 ☐ Yes 2 💢 N		
or 28a-f show be notified at Director	10e. Street and Number	orges r	OI-C Wa	10f. Zip Coo			10g. Citizen of W	/hat Country?		
0 8 0	10710 River View	Road		207	1.4		U.S.A.			
		12. Was Decedant Evar in U.	S. 13. W		of Hispanic Origin? (S Cuban, Maxican, Puer	Specify Yes or No		- Amarican Indian,		
or litems	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XNo				to Hican, etc.)		k, White, etc.		
, g	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Dates:	1	□Yes 2∏	No Specify:		Specify:	White		
"naturel" adical Ex	15. Decedant's Edu (Specify only highest grad		(Give k	ent's Usual Oci and of work do	ine during most of wo	orking	16b. Kind of Bu	sinass/Industry		
	Elemantary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use re	tired)					
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Se ver	17. Fathar's Nama (First, Middle, Last)							9		
la markad or raumatic eve	Charles M. Gray 19a. tnformant's Name/Relationship (T)	me Print)	19h Mailin	Address /C+	AGELIN	ie Emma E		State, Zin Code)		
7 la r traui										
of hearth end Merkelitem 27 Is markel r other traumatic	Charles R. Gray / 20a. Method of Disposition	Brother 20b. Pl	ace of Dispos	ition (Nama o	37, Charlo	Date Date		OZZ City or Town, State		
Department of relationships of the page of	1 X Burial 2 ☐ Cremation 3 ☐ F	temoval from State	ametery, crem			11/20/0	07:	han Massall		
e straight of the straight of	4 Donation 5 Other (Specify)		Contract of			11/30/9	Clin	ton, Maryland		
mpo any ii	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A.									
	23a. Part1. Enter the disease or compl	, Maryla	Maryland 20650							
	shock, or heart failure. List only or	ications that causad the daaline causa on each line.	Do not ente	r tha moda of	dying, such as cardia	ic or respiratory a	rrest,	Interval Between Onset and Death		
ysician Medical	Immediate Cause (Final		IPLE II			T				
aminer	disease or condition rasulting in death)	SEVENE	1384	TNP	DAMAGE					
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sician and burial-transit	On any of the first over divines	5. FALL	as a consequ	ience of/:						
EX3	if any, laading to immediate causa. Enter Underlying	D00 t0 (0t	as a consequ	ianos orj.						
physician the buria	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury that initiated events Due to (or as a consequence of):									
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ettending for use es clan/Me		d								
ed for	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the un	darlying caus	given in Part I.	23b. Dld	tobacco use cor	ntributa to the causa of dec		
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b g						-				
sate has been signe page 2 should be completed by						24a. Was perfo	an autopsy ormed?	24b. Were autopsy finding available prior to		
as be								complation of causa of death?		
page 2						10	Yas 2 No	1 ☐ Yes 2 ☐ No		
ertific sctor	25. Was case refarred to medical examiner?	la anitali.			_	eath (Check only	ona)			
등 등	1 Yes 2 No		ER/Outpatient			Home 5 Rasi				
eetn. or: After thi the funeral cation: 1	27. Manner of Death	28a. Data of Injury (Month, Day Year) 11-21-99	28b. Time of 12 10		Injury at Work?		how injury occurr FIRE DRI			
	2 Accident Investigation 3 Suicide 6 Could not be			M factory of	1 Yas 2 Ñ No					
Direct In by	4 Homicida determined	28e. Placa of Injury - At he building, etc. (Specify	1)	et, factory, of	ica			FO' RIVERVIEW		
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	(Check only one)	sician: To the bast of my knowner: On the basis of axaminat and manner stated.	ion and/or Inv	estigation, in	ny opinion, death occ	curred at the time,	date and placa,	and dua to the cause(s)		
Fun Fun dies	29b. Signature and tilla of certifiar	and marmar stated.		29c. Li	ense number	T	29d. Data signed	d (Mogth, Day, Year)		
rithin 24 hours after deet o the Funeral Director: ompletely filled in by the Medical Certifical		7		-	12662		11/57/	d (Mooth, Day, Year)		
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To the Function of the Functio	· aux	and the desired of the state of	00a) (T:	1	13662					
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State of Maryland /	Department of Health and	Mental Hygier
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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death NOVEMBER 02, 1999 **Physician** 11:30AM Pearle Lucille Gatton /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Hours 1 ☐ M 2 💢 F Yrs. 215-36-4525 84 Director May 10,1915 Maryland Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10e, Stete 10b. County permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Machael Examinet. That has not injury or other traumatic event, the Machael Examinet. 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland St. Mary's Scotland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 49968 Long Neck 20687 U.S.A. Road Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: þ Specify 3 X Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Eugene Peacock Cora Carroll 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley G. Jones/ Daughter 25220 Jones Road, Mechanicsville, Maryland 20659 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 11/6/99 | Ridge, Maryland St. Michael's Cemetery 21. Signature of Funeral Service Licen 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 hinter the mode of dying, such as cerdiac or respiratory errest, Even Prodine 23e. Pert1. Enter the disease, or shock, or heart feilure. Line complications that caused the death Approximete Interval Between Ogset and Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner ettending physicien end for use es the burial-transit Sequentielly list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Box 68760, Physician/Medical been signed by the ette should be deteched for P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, þ Manser 24b. Were autopsy findings evelleble prior to 24e. Wes en eutopsy performed? Completed completion of ceuse of deeth? hes NA 2 No 1 Yes 2 No funeral director, Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

GATTON

PEARL LUCILLE

NAME:

After this certificate Division of Vital Hospital or Attendin 24 hours efter deeth.
 Funeral Director: Aft completely filled in by To the Hospital of within 24 hours e To the Funeral D

> State Registrar

title of certifie

29c. License number

🖅 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

1 ☐ Yes 2 ☐ No

er: On the besis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Neme e of pleted ceuse of deeth (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

2 Medical Ex

1 Naturel

2 ☐ Accident

3 Suicide

(Check o

31. Dete iled (Month, Dey, Year)

NOV

29e. Certifier

29b. Signet

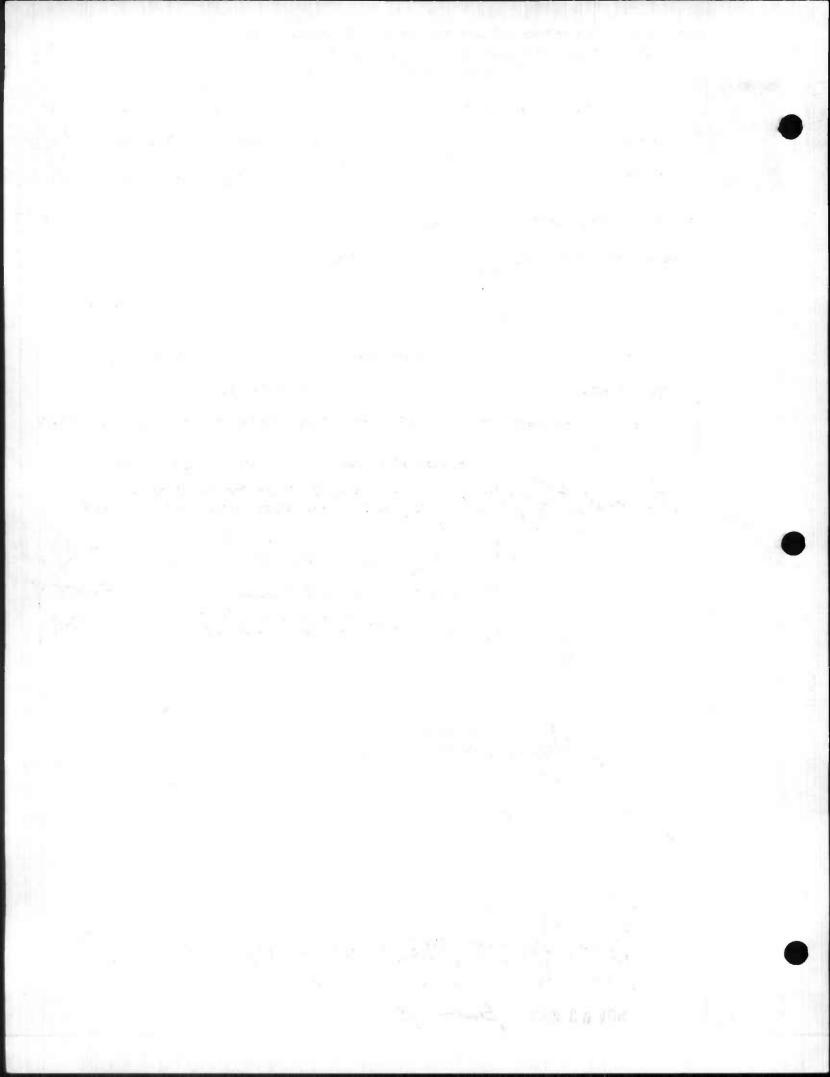
Medical

4 Homicide

JAMES P JARBOE HOLLYWOOD, MD. 20636 DR.

32. Registrer's Signeture

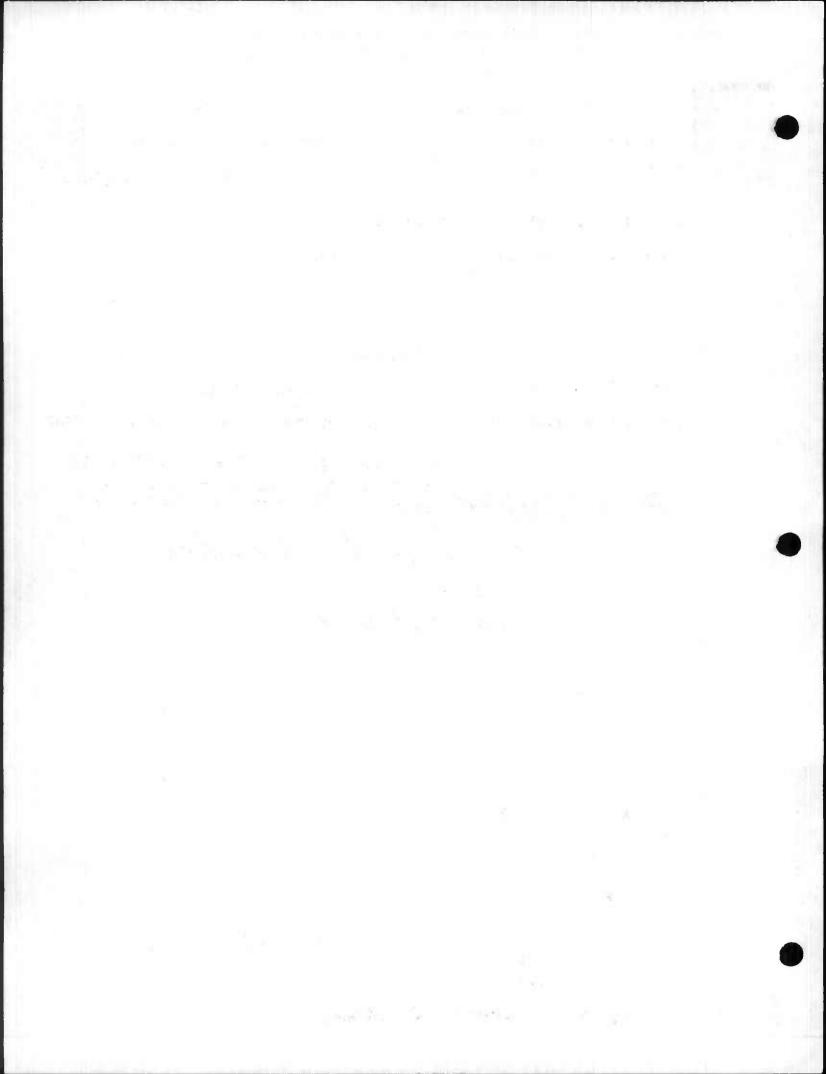
Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



NAME: CHARLES GREENWELL

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** NOVEMBER 87, 1999 Charles Franklin Greenwell 11:15AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dep Year)
Months Days Hours Min. (Month, Dep Year)
March 5, 1931 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral ™** M 2□ F 218-24-3468 68 Yrs. Director Maryland Usuel Residenca of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: if itam 27 is marked other than "natural", or items 23s or 28s-f shov injury or other treumstic event, the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24650 East Montiego Drive 20636 U.S.A. Funeral death 12. Was Decedent Ever In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours efter M Yes 2 No If Yes, Give Yaar or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within:
Department of Health and Mental Hygiens important: if Item 27 is marked other than any Injury or other traumate Elementary/Secondary (0-12) College (1-4or 5+) 12th Carpenter U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be John Joseph Greenwell Grace E. Higgs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Charles R. Greenwell /Son 27 Wainwright Avenue, Annapolis, Maryland 21403 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/11/99 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Jardene. 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heert feilure. List only one cause on each line. Physician with Helaskasis /Medicai Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Angening attending physician and for use as the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Lest Box 68760, Physician/Medical P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, p 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen hes certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending Investigation Division or Attending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Diractor: 3 Suicide 6 Could not be determined Location (Street end Number or Rurel Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) completely and manner stated. 29b. Signature end title of certifiar 29c. Licansa number 29d. Date signed (Month, Dey, Year) 00 53262 11.08-1999 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) 8 HOLLYWOOD, MD. 20636 DR. MIRATIQULLAH HESSAMI 31. Date filed (Month, Day, Year) Registrer's Signature State NOV 0 9 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 14, 1999 Helen Frances **Physician** 8:05AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Leonardtown St. Mary's St. Mary's Hospital Hours Min. May 19, 1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (Stete or Foreign **Funeral** Days 215-50-7422 85 Yrs Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland St. Mary's Leonardtown 1 ☐ Yes 2 ■ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39807 Big Chestnut Road 20650 United States Funeral 14. Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiane. 1 ☐ Yes 2 ■ No if Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify: White þ 3 ■ Widowed 4 Divorced Completed 18a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health end Mantal Hygien. Important: If Item 27 is marked other the eny Injury or other traumatic event Homemaker n/a 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ernest Francis Wheeler Ella Josephine Latham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Robert M. Guy, Son 22839 Bunny Hill Lane, Bushwood, Maryland 20618 20b. Place of Disposition (Name of cametery, crematory or other place 20c. Location - City or Town, Stete 20a. Method of Disposition Sacred Heart Cemetery 1 ■ Burial 2 □ Cremation 3 □ Removal from State 11-17-99 Bushwood, Maryland 4 Donation 5 Other (Specify) ^{22. Name end Address of Facility} Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 Rizzo, 23a. Part1. Enter the discrese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician immediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to (or as a consequence of) Physician/Medicai Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760. that the death certificate be Due to (or as a consequence of): esn Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably à 24a. Was an autopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed peeu Vital Be 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 | No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o 27. Manner of Deat 28c. injury at Work? 28d. Describe how injury occurred After Division or Attending 1 Naturat 5 Pending investigation 1 Yes 2 No eftar death. Director: 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated.

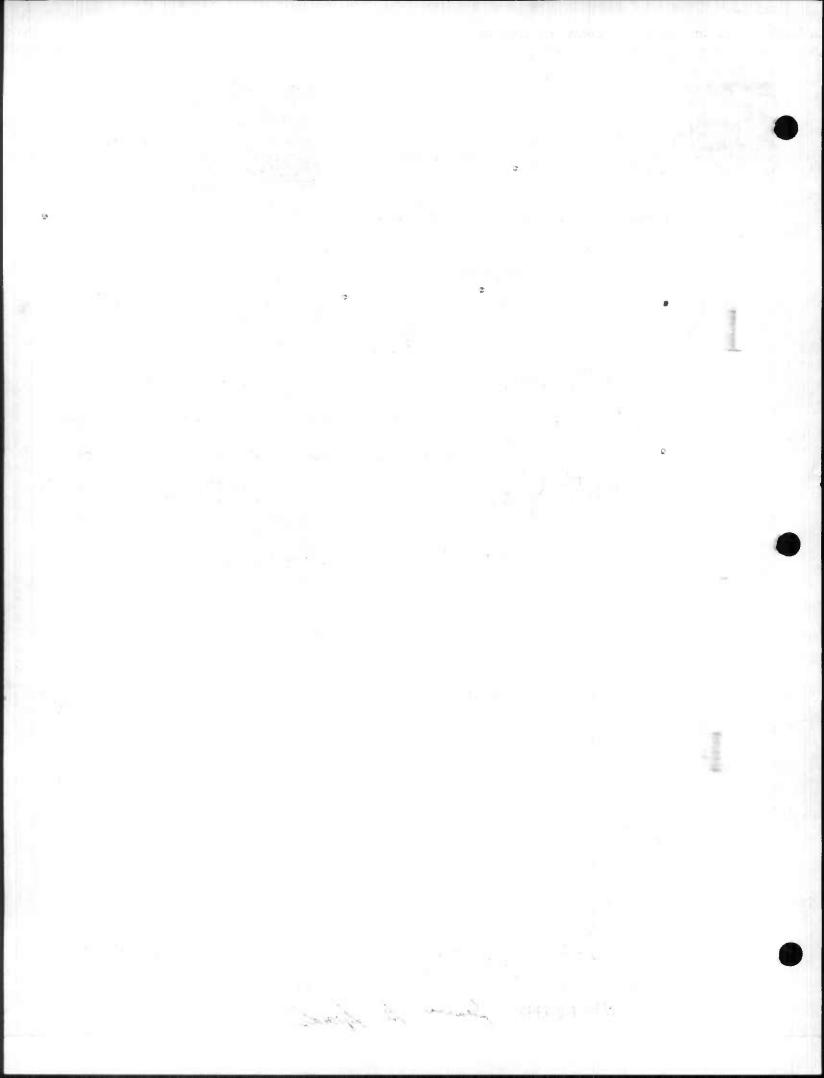
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Dey, Yeer) 29b. Signature and tile of sertifie 11-14-77 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. WILLIAM D. BOYD II LEONARDTOWN ,MD 20650 31. Date filed (Month, Day, Yeer) 9 1999 32. Registrat's Signature State

Registrar

GUY

FRANCES

HELEN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37904 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Charles Aubrey November 9, 1999 6:30 p.m. Graves 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans' Home Charlotte Hall ST. Mary's If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) August 26, 1912 Birthplace (State or Foreign Country) 216-12-4938 1 ■ M 2 □ F Months Days Hours Min 87 Maryland Usuai Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ■ No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44569 Clarks Landing Road 20636 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ■ Yes 2 □ No If Yes, Give ₩₩/Т 11. Merital Status Was Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ■ No Specify: White WWII 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Building Industry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Franklin Graves Mary Adelaide Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Goldsborough, Daughter 44569 Clark's Landing Rd., Hollywood, MD 20636 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ■ Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 11-18-99 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart lattire. List only one cause on each line. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 Approximate tnterval Between Onset and Death more thun Immediate Cause (Final CHRONIC RENAL FAILURE Due to (or as a consequence of): disease or condition resulting in death) YEATL MORE THAN HYPERTENTION Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated assets) Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner pue burial-tran certificate be

Physician

/Medical

Examiner

Funeral

Director

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Maryland

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permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natureny or other traumatic event, I'm Medical.

Examiner Physician/Medical þ Completed Be 2 Certification: To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi

27. Manner of Death Natural

1 ☐ Yes 21 No 5 Pending investigation 5 ☐ Accident 6 Could not be determined 3 Suicide 4 Homicide 29a. Certifier (Check only

28a. Date of Injury (Month, Day Year)

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier

29c. License number D 50653 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHURCH TON DEALE

GYAN CHAND SURANA ROAD. DEALE MD-20751

State Registrar

Medicai

books

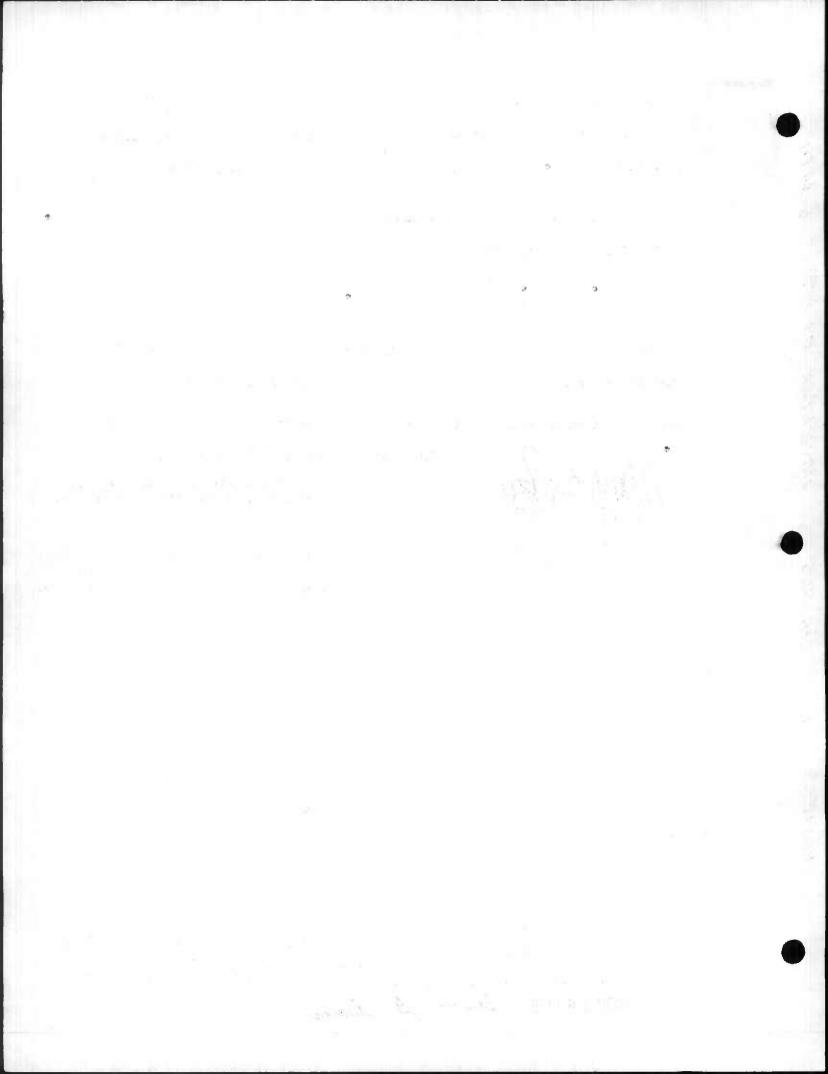
Division of Vital or Attending Physician:

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After

death.

SHARLE



1.0.D-11-12-99 at 5:20 AM

1. Decedent's Name (First Middle Last)

Granduille Guiney

Physician Month Yeer GRANVILLE CHESTER GUINEY NOV. 1999 5:20 A.M. /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner AVALON MANOR NURSING HOME HAGERSTOWN WASHINGTON If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 77 Yrs. Director 221-10-9095 11/19/1921 PENNSYLVANIA Usual Residence of Decedent deeth with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director BERKELEY MARTINSBURG 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 703 PORTER AVE. 25401 12. Wes Decedent Ever in U,S. Armed Forces?

1 Dives 2 Dives 17 Yes, Give 8/42 TO Yeer or Detes: 2/46 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 🖾 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratirad) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9 GRINDER STEEL MILL permit. Pages 1 and 2 should be file Deportment of Health and Mentel Hy, Important: If item 27 is marked other any injury or other traumatic event, OMCS. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) CLYDE CHESTER GUINEY ANNA LYDIA COX 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DAVID A. GUINEY / SON 618 PEILA AVE., COTTONWOOD, AZ 86326 20e. Melhod of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stale 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) SMITHSBURG CREMATORY 11/12/99 SMITHSBURG, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility BROWN FUNERAL HOME BROWN FUNERAL HOME, 327 W. KING ST. PO BOX 821, MARTINSBURG, WV 25402 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximele Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) 6 months Examiner Alcohahem sician end burief-trensit Sequentielly ltst conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) ettending physician for use es the burie of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown þ 24b. Were eutopsy findings eveitable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical exeminer? 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how Injury occurred Division 1 Naturel 2 Accident 5 ☐ Pending investigation al or Attending sefter deeth. Director: After 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aff To the Funeral DI completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D44996. NOV 12, 1999. 30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print) Dr. Zafar Malik 20311 Lappans RD Boonsboro, MD 21713 31. Date filed (Month, Day, Year) NOV 16 1999 32. Registrer's Signature State parks Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Dete of Deeth

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death HICKS Month ADELE NOVEMBER 16 12:08 Am 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth BRADFORD DAKS NURSING & REHAB CENTER MARYLAND PRINCE GEORGES CLINTON If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 210-10-1245 1 □ M 2 X F 83 Yrs February 15,1916 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Upper Marlboro 1 TYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11303 Sherrington Court 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Retail Clerk Private 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Payne Ruth (Unknown) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley P. Ford/Niece 11303 Sherrington Court, Upper Marlboro, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 11/20 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Fernwood Cametery 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Philadelphia, PA 21. Signeture of Funeral Service Licenson J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediete Cause (Finel OF THE BREAST WITH METASTICES diseese or condition resulting in deeth) MONTHS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or items 23s or 28s-f show

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Funeral

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Completed

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Hygiene.

permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien, important: if floor 27 is marked other twant injury or other traumetr.

the Maryland

Baltimore, Maryland 21215-0020

Examiner

attending physician and for use as the burial-transit Physician/Medical 3 signed l peen page 2 certificate edical Certification: To

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

þ Completed Be

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics stely filled in by the funeral director. un 24 hour. To the I

State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Menner of Deeth

1 Naturel 2 Accident

3 Suicide

4 Homicide

29b. Signeture and title of certifier

28a. Date of Injury (Month, Day Year)

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) NOVEMBER 17, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

end address of person who completed cause of death (Item 23a) (Type, Print)

Old Line Centre #207 WISOTSKY waldorf mo 20402 12070 22 Registrar Signature

Registrar

DHMH 16 Rev 6/95

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b Time of

184 2 8 1855 James B. Janker

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Month 0628 Dorothy Mae Harris NOVEMBER 15, 1999 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES JUNIPER TREE LANE CAPITOL HEIGHTS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Deys Min Months Houra 577-20-3916 1 M 2 F 8/30/21 Wash., D.C. Usuet Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Md. P.G. Cedar Heights X□ Yes 2□ No 10g. Citizan of Whet Country? 10e. Street and Number 10f. Zip Code 5807 Junipertree Lane 20743 U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Yes 2 No 1 □ Naver Merried 2 □ Married 1 ☐ Yes 2 Ø No Specify: Specify: Black 3 → Widowed 4 □ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 10th Surgical Technician Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Samuel Flood Louise Stewart 19b. Mailing Address (Street end Number or Rurel Route Numbar, City or Town, Stete, Zip Code) 19e, Informant's Neme/Relationship (Type, Print) Dolores Ann Luckett/Daughter 5706 Junipertree Ln., Cedar Hgts., Md. 20743 20b. Place of Disposition (Neme of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other piece, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 11/19/99 Harmony Mem. Park Landover, Md. 21. Signatura of Funaral Service Licensea 22. Name end Addrass of Facility H.S. Washington & Sons Co., Inc. rall any 4925 Burroughs Ave., N.E., Wash., D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final & CONGESTIVE HEART FAILURE disaase or condition resulting in deeth) Due to (or as a consequence of) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequentielly list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Diseese or Injury that initiated events resulting in daath) Last Due to (or es a consequence of) Dua to (or as a consequanca of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLHUS 24b. Were autopsy findings available prior to 24e. Was en autopsy performed? completion of causa of death? 1 ☐ Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 ANatural 5 Pending investigation

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature

4 Homicide

(Check only one)

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked othe any Injury or other traumatic event, phose.

filed within 72 hours after deeth with Hygiene.

Baltimore, Maryland 21215-0020

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Funeral

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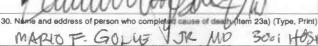
Registrar

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31. Date filed (Month, Dey, Year) NOV 1 8 1999

MARIOF. GOL

6 Could not be determined



3001 HOSPITAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) end mennar es stated.

Madical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. Licansa number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

DRIVE CHEVERLY

32 Registrar's Signature

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

Action pro markets

0000 17/30

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month GARY ALBERT HOPKINS, SR. NOVEMBER 11,1999 10-20 AM 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S LANHAM DOCTOR'S COMMUNITY HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 577-74-7838 Hours 10 M 2□ F 45 January 28, 1954 Washington, D.C. Usual Residence of Decedent 10e Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 Woodberry Street 20706 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify **Black** 3 ☐ Widowed 4 ☐ Divorced Yeer or Deles: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electrician Private 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willie P. Hopkins Beatrice Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Neme/Reletionship (Type, Print) Marion Hopkins/Wife 9707 Woodberry Street, Lanham, Maryland 20706 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) Date 11/17 20c. Location - City or Town, Stata Ft. Lincoln Cemetery 1999 4 ☐ Donelion 5 ☐ Other (Specify) Brentwood, Maryland 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 Terce 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) most Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown

Physician /Medical Examiner

Important: If Item 27 any injury or other to

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Physician

/Medical

Examiner

Director

Completed

Be

Funeral

Director

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8 and Mental

Examiner

Completed Be To 27. Menner of Death

25. Was case referred to medical exeminer?

Physician/Medical à

Sign this death. filled in by

physician s the burial Box 68760. P.O. Records, Division of Vital Attending Physician:

Certification:

ician and burial-transit The lew requires that the death certificate be executed

Ne Hospital or Attandi n 24 hours after death Ne Funeral Director: A To the Hosp within 24 ho To the Fune completely fi

DHMH 16 Rev 6/95

Registrar

Medical

yh 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

28c. Injury at Work?

1 Yes 2 No

2 ER/Outpatient 3 DOA

28b. Time of

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

180 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were sutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

D45660 le 124, Bowie MD 20715 IN,

24a. Was an autopsy performed?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2NNo

28d. Describe how injury occurred

31. Dete filed (Month, Dey, Year)

29b. Signeture and title of certifier

1 ☐ Yes 2 No

1 Nelurel

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

NOV 1 6 1999

5 Pending investigation

6 Could not be determined

32. Registrer's Signeture

1X Inpatient

28a. Dete of Injury (Month, Dey Year)

The state of the second

			State of Maryland / Department of	Health and Mental Hy	-	37909			
Ą	mend # Physic		a. Part 1. Per Phys. PGC 11-16-99 cr Certificate o 1. Decedan's Nama (First, Middla, Last) Irene Hudgins Huber	2. Data of D	/ Day / Year	3. Tima of Death 99 5:47 A			
	/Medi Examir		4a. Facility Nama (If not institution, give street and number) Doctor's Community Hospital	WOVEM 4b. City, Town, or Location of Dea	Der 11 11	ath			
	Funeral Director		5. Social Sacurity Number 6. Sax 1 M 25F 82 Yrs. Months Day	ar If Undar 24 Hrs. 8 Data of Bi	irth 9. Bir	9. Birthplaca (Stata or Foraign Country) ennessee			
	Maryland f show	or	Usual Rasidance of Dacedant 10a. Stata 10b. County Maryland Prince George's Bowie			10d. Insida City Limits ↓ Yes 2 No			
with the A Se or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code 5005 Patuxent Riding Lane 20715		10g. Citizen of What C	ounfry?				
020	d within 72 hours after death with the Maryland ilene. Then "natural", or items 23a or 28a-1 show the Modical Examinal must be notified at	by Funera	11. Marital Stafus 12. Was Decedanf Evar in U.S. 13. Was Dacedenf o	of Hispanic Origin? (Specify Yas or Nuban, Mexican, Puarto Rican, atc.) Io Specify:	Black, Whi				
21215-0020	filed within 72 ho Hygiena. ther than "naturi ent, the Medical.	Completed	Eiamantary/Secondery (0-12) College (1-4or 5+) lifa. DO NOT usa reti	na during most of working	16b. Kind of Business	Andustry			
Baltimore, Maryland 2 permit. Pages 1 and 2 should be filed v Department of Health and Mental hygies Important: If item 27 is marked other to any injury or other traumatic event, the once.	To Be Co	11 Homemaker 17. Fathar's Nama (First, Middla, Last) Peter Hudgins	18. Mothar's Nama (First, Middle Nannie	Own Home o, Meiden Surnama) Claxton					
		Patricia A. Huber/Daughter 20a. Mathod of Disposition 1	Data	owie, MD 2 20c Location - City or 9 Waldorf, Evans Fune	0715 Town, Stata MD ral Home, In				
ĵ	Physician /Medical Examiner	er.	23 Part. Enter the disease, or complications that caused the death. Do not enter the mode of death on a cause on each line. Immediate Causa (Final disease or condition resulting in death) Due to for es a consequence of):		Approximata Interval Between Onsat end Deeth 2				
BOX 58/50,	leath certificate be axecuted attending physician and I for use as the burial-Iransit	/Medical Examiner	Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Ceusa (Disaasa or Injury that initiated avents rasulting in death) Lasi	Lion (Sport		2 weeks 2 weeks >104-s.			
s, r.o. u	v requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medic	Part II. Other significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting in the underlying cause of the significant conditions contributing to death buf not resulting to the significant conditions contributed to the significant conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions condit			e to the cause of death? Probably 4 Unknown			
tecord		Completed b	init-ul Regu-gitation		s an autopsy 24b. ormad?	Wara autopsy findings availabla prior to complation of causa ot death?			
VIII	Physician: The law this certificate has t ral director, paga 2 s	o Be Co	25. Wes casa rafarred to madical axaminar? 1 Yes 2 No Hospital: 1 Inpatiant 2 FR/Outpatient 3 DOA C	26. Pleca of Daath (Check only		1 ☐ Yes 2 ☐ No			
Ing Phy I. After this funeral o	ertification: To	27. Mannerof Death 1 Natural 5 Panding (Month, Day Yaar) 28b. Time of Injury W	jury at 28d. Describe	how Injury occurred (Streat and Number or River, State)					
2	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Cer							
	To the comple	Mec	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3/ 00 /	29d. Data signed (Mon				
	(0)		30. Name and address of person who complated rates of death/(Itam 23a) (Type, Print)	3/001 00 5-een wa een belt, MI	y Catr. D > 20770	1,#430			
	Sta Registr		31. Data filed (Month, Day, Year) NOV 1 6 1999 32. Registrer's Signetura						

B. Spale

1860 S. J. J.

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Hernandez 11-4-99 Rosa 11:45pm /Medical 4a. Facility Name (If not institution, give street end numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Takoma Pk Washington Adventist Montgomery County 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplece (Stete or Foreign **Funeral** Deys 1□ M 2√X 75 577-82-2436 Yrs. Salvador Director 8-31-24 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with tha Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or othar traumatic event, to be a contact traumatic event, to be a contact traumatic event. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Hyattsville Prince George Md Director 1 Yes X No 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 20783 2021 Lewisdale Dr USA Funeral 12. Wes Dacedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 13. Was Dacedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, efc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merriad XX Married Baltimore, Maryland 21215-0020 Yes 2 No Spacify Specify: White by 3 Widowed 4 Divorced El Salvador Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Domestic Elementery/Secondary (0-12) College (1-4or 5+) Housewife 6th 18. Mother's Name (First, Middla, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Silva Angela Palma Daniel Lo 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Hernandez (Son) Salvador 2021 Lewisdale Dr Hyattsville Md 20783 20b. Placa of Disposition (Neme of cametery, crematory or other place)

Chesapeake Crematory 11-8-99 Beltsville Md 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Sterling Funeral Service 21. Signeture of Juneral Service Licerse 1601 Kenilworth Ave NE Wash DC 20019 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrasf, only one cause on each line. er pre diseas heart feilure. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) CANDIO DULMUNIARY ARREST

Due to br as a consequence of): Examiner Examiner DIABETES Due to (or es e consequence of):

IPET Choles Terolemia Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Lest Box 68760. The law requires that the death certificate be Physician/Medical use Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably Unknown HY BENTENSION Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior fo complation of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes cartificate No 1 ☐ Yes > No Hospital or Attanding Physician: funaral director, 25. Was casa raferred to medical examiner?

1 Yes 254 No Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient SER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred Aftar 1 Naturel 2 Accident 5 Pending Investigation efter death. 1 TYes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. To the Within 2 29b. Signature and title of certifie 29c. Licensa number 29d. Date signed (Month, Dey, Yeer)

State Registrar

istrar NOV 1 5 1999

31. Dete filed (Month, Day, Yeer)

30. Neme end address of person who completed carls

layton

32. Registrer's Signature

dughn

Str

1400 Spring St. Solver Spring Md. 20910

e of deeth (Item 23e) (Type, Print)

200 E .

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 2 7 9 1

	1. Decedent's Name (First, Middle, La			-,	of Death	2. Date of Deat		3. Time of Death		
Physician /Medical	Rose Hayducko					November	2,1999 Yaar	8:45 p.m		
Examiner	4a Facility Name (If not Institution, giv. St. Mary's Nursi				Leonard		4c. County of Dea			
Funeral Director	132-03-0330		n yrs. last birthda 2 Yrs	Months	Yaar If Undar 24 Hr Days Hours Mir		9. Bir 21, 1917 Ner	thplace (Stata or Forei buntry) V Jersey		
the Maryland 28a-f show nothing at	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mar		c. City, Town or Cali:	Location Fornia				10d. inside City Limit		
iffer death with the Maryle r thems 23e or 28e-f ehor inter must be nothlind at Funeral Director	10e. Street and Number 44094 Sycamore La	ne		10f. Zip C	code 20619		og. Citizen of What Co United Sta			
urs after dea	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yas, Give Yaar or Datas:	r in U,S. 1		nt of Hispanic Origin? (y Cuban, Mexican, Pue No Specify:	Specify Yes or No- into Rican, atc.)	14. Race - Ame Black, Whit Specify: W	te, etc.		
ed within 72 ho ygiene. Ner than "natura it, the Wedical E	15. Decedent's Ec (Specify only highast gra Elementery/Secondery (0-12)	de completed) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) Seamstress			16b. Kind of Business Garment II			
	17. Father's Name (First, Middle, Last) Michael Zwarun					eme (First, Middle, M ine Vitnak	faiden Sumame)			
s 1 and 2 should I Heelth end Men tam 27 la marke other traumatic	19a. Informent's Name/Relationship (Edward Hayducko, I				Street end Number or F					
permit. Pages 1 and: Department of Heelth Important: If Item 27 I eny Injury or other tr.	20a. Method of Disposition 1 Buriel 2 Cremation 3 4 Donation 5 Other (Specific	memoval from State	20b. Place of Discemetery, of Immacula				exington I	Town, State Park, Mary		
permit. Pages Department of Important: If it eny injury or of	21. Signature of Funeral Service Complete 22. Nama and Address 23. Nama and Address 24. Nama and Address 25. Nama and Address 26. Nama and Address 26. Nama and Address 27. Nama and Address 28. Nama and Address 2					rinsfield	Funeral Ho	ome, P.A. 20650-027		
Physician /Medical Examiner	Immediate Cause (Finel disassa or condition resulting in death)	a Non Hos	hora			onset end Death				
ding physicien end se os the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	e to (or as a cons							
at the deem centre of the ettending eteched for use a Physician/Me	Part II. Other significent conditions contributing to death but not resulting in the underlying				use given In Part I.	23b. Did to	bacco use contribut	o use contribute to the cause of dea		
						1 🗆 Y	98 2□No 3□F	Probably 4 Onkn		
2 2 0	Tumbor spine,	rtis		0		24a. Wes e perform		Were autopsy finding available prior to completion of cause of death?		
						1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No		
this certifical director,	25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospital:	2 ER/Outpa	tient 3 DOA	Other:	eath (Check only on	a) inca 6 ☐Other (Spe	acifu)		
Attending Physical death. ector: After this by the funeral di	27. Manner of Death 1 Natural 5 Panding 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time		c. Injury at Work? 1 Yas 2 No	-	ow injury occurred	sony,		
To the hospital or Attanding Privalling 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	3 Sulcida 6 Could not be determined	28e. Place of Injury building, etc. (5	jury - At home, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
in 24 houn in 24 houn the Funera pletely fille		ysician: To the best of m niner: On the basis of ex and manner stated	aminetion and/or							
Withi To the	29b. Signature and title of certifier	1	>		License number 19917	2	9d. Date signed (Mon	th, Day, Year)		

1834 D 5 1835 James & Spender

State of Maryland / Department of Health and Mental Hygiene 99 37912

						Certi	ficate of	Death		Reg. No.		01312
	Ohania		1. Decedent's Name (First, Middle, La	st)					2. Date of D		Voor	3. Time of Death
	Physic /Medi		FRANCIS	LEROY		HI	GGS		NOVEM	BER 16,	1999	11:57AM
	Exami		4e. Facility Name (If not institution, giv	re street end number)				4b. City, Town, o	r Location of Dea	th 4c. Coun	ty of Death	
			St. Mary's Hosp	oital				Leonar			Mary	's
	Funeral Director		219-16-09/6		e (In yrs. Ia 91		If Under 1 Yea Months Days			1908	Cour	place (Stete or Foreign office) Yland
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Local	ion	-				10d. inside City Limits
	fanyla sho	5		-1			17011				1	1 ☐ Yes 2⊠ No
with the	the Marylar 28a-f show	Director	Maryland St. Mary	S	TEC	nardtown	10f. Zip Code			10g. Citizen o	f What Cour	
	with a or	ā	21.895 Newtowne Road							AND PROPERTY.		nu y r
	leath w	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13 Wa	20650 s Decedent of	Hispanic Orlgin?	(Specify Yes or N		S a	cen Indian
Maryland 21215-0020 d 2 should be filed within 72 hours after d th and Mental Hydiene.	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is merked other than "natural", or items 23a or 28a-f show faurratic event, Ita Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1 Yes 2 No If Yes, Give 1 Yes				erto Ricen, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Õ	72 hours "natural",		15. Decedent's E	ducation		16e. Deceder	t's Usual Occu	upation	2177	16b. Kind of		
215	hin 7	ple	(Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5	5+)	life. DO	d of work done NOT use retir	e during most of w ed)	rorking			
2	with a	Completed	3rd grade	0011090 (1 401)		Truck	Drive	r		Oil C	ompany	У
pu	ai Hy softh	Be	17. Father's Name (First, Middle, Last,					18. Mother's N	eme (First, Middle	e, Maiden Sume	me)	
<u>X</u>	Ment Ment arked	10	James M	utchell	F	liggs		Julia	M	ae	Bush	
lar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Stree	et end Number or	Rurel Route Numi	ber, City or Tow	n, Stete, Zip	Code)
Baltimore, A	permit. Pages 1 and 2 should be filed within 72 ho Department of Haalth and Mental Hygiene. Important: If item 27 is merked other than "natur any Injury or other traumatic event, Ita Medical once.			Niece)				58, Leon		1		
	of H If ite		20a. Method of Disposition 1 Disposition 3	Removal from State	20b. Ple cer	ce of Dispositi n <i>etery</i> , creme	on (Neme of ony or other pi	lece)	Date	20c. Location		
	men men ment: juny		4 Donation 5 Other (Specif	γ)	Metro	politan	Cremato	ry	11-17-199	9 Alexan	dria, V	Virginia Virginia
Ba	permi Depar import any Ir		23a. Part Emer the disease, or com shoot, or heart feilure. List only	plications that caused	the death.	Ma P.0	tting	ress of Facility ley-Gar 70, Leonard ving, such as cerd	diner dtown, Mar jac or respiratory	Funera yland 20 arrest,	1 Hon 650	ne, P.A. Approximate Interval Between
ı	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	6.		6	leed	2				Onset and Death
		<u>.</u>	resulting in death)			as a conseque	-					5 11
	led isit	nine		b. •	PYP	oten	hoen	/				2 Hour
	icata be executed physician end s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury		Due to (or a	as e consequ <i>e</i>	nce of):					2 Hours
60	siclar buris	le:	ceuse. Enter Underlying Cause (Disease or Injury thet initiated events	c		Seps	SIS					X HOSTS.
x 68760,	sertificats ding physes as the	/Medical	resulting in deeth) Lest	d	Due to (or a	is a conseque	nce of):					
Bo	eath ce attend I for us	clan									1	
P.O.	requiras that the death certificate be executed seen signed by the attending physician end hould be datached for use as the burial-transit	Completed by Physician	Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the unde	orlying ceuse g	jiven in Pert I.		tobacco use c		o the cause of death bably 4 Unknow
Vital Records,	Z S								24a. Wa perl	s an autopsy ormed?	av	ere autopsy findings vailable prior to impletion of ceuse death?
=	The ata h	S							1 🗆	Yes 2 No	1[☐ Yes 2☐ No
/ita	iclan: T	Be	25. Wes cese referred to medical examiner?					26. Place of D	eath (Check only	one)		
of	5 00 0	ပ္	1 ☐ Yes 2 XNo	Hospital: 1 tnpatie	-	R/Outpatient	3□ DOA O	ther: 4 Nursing	Home 5□Res	idence 6 🗆 O	ther (Specif	ý)
Division o	ling After fune		27. Manner of Death 170 Natural 5 Pending 2 Accident Investigation		ry y Year) 2	8b. Time of Injury		ury et ork?] Yes 2 No	28d. Describe	how injury occi	urred	
Divi		Certification:	3 Suicide 6 Could not b 4 Homlcide determined	28e. Place of Injubuilding, etc.	ury - At hom c. (Specify)	e, farm, street	, factory, office	9	28f. Location City or To	(Street end Nun own, Stete)	iber or Rure	el Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir complately filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicisn: To the best of niner: On the basis of and manner sta	examinatio	edge, death or n and/or inves	ccurred at the tigation, in my	time, dete end ple opinion, death oc	ce, end due to the curred at the time	ceuse(s) end r , date and place	nenner as s s, and due to	tated. o the cause(s)
	To the within 7 To the comple	Σ	29b. Signeture end title of certifier	A				nse number		29d. Date sign		
			1)8ha	h			D 1	47066	9	11-	16 -	99.

HOLLYWOOD, MD. 20636

State

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)
DR. AVANI D. SHAH HOLLYWO

32. Registrar's Signeture

31. Date filed (Month, Dey, Yeer) NOV 1 9 1999

LEROY HIGGS

FRANCIB

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0808 November 1999 Marguarite Lee Hull 21 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Hagerstown Was Washington County Hospital Washington If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 21 F Months Yrs. Director 218 24 1960 February 11, 1921 Virginia Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits flem 27 is marked other than "natural", or flema 23a or 28a-f ahow other treumetic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17214 Bakersville Road 21713 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 □ Never Merried 2 □ Married Specify: White 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry oe filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other eny injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jennings Bryan Constable Nina Dale Davis 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) erna L. Larrick Daughter 17228 Cloverleaf Road Hagerstown, Md.21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Rest Haven Cemetery 11/24/99 Hagerstown, Md. 22. Name and Address of Facility Gerald N. Minnich 21. Signeture of Funerel Service License 305 N. Potomac St. mue Funeral Home Hagerstown, Md.21740 Approximete Intervel Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel diseasa or condition resulting in death) Men Ea 4 days Examiner Due to (or as a con Examiner Trues burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of) physician Physician/Medical Due to (or as a consequence of) USB Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? D.0 Yea 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed has 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: Inpatient Other: 4 Nursing Home 1 Yes ZNO 2 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred Vetural 2 Accident 5 Pending investigation death. 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital or A within 24 hours after To the Funeral Direct hours after

Registrar **DHMH 16 Rev 6/95**

State

edicai

(Check only one)

29b. Signeture end title of certifier

May E

31. Dete filed (Month, Day, Year)

MILL

22

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

1999

5772881

32. Registrer's Signature

Hull, Marquerite

MAGERST

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

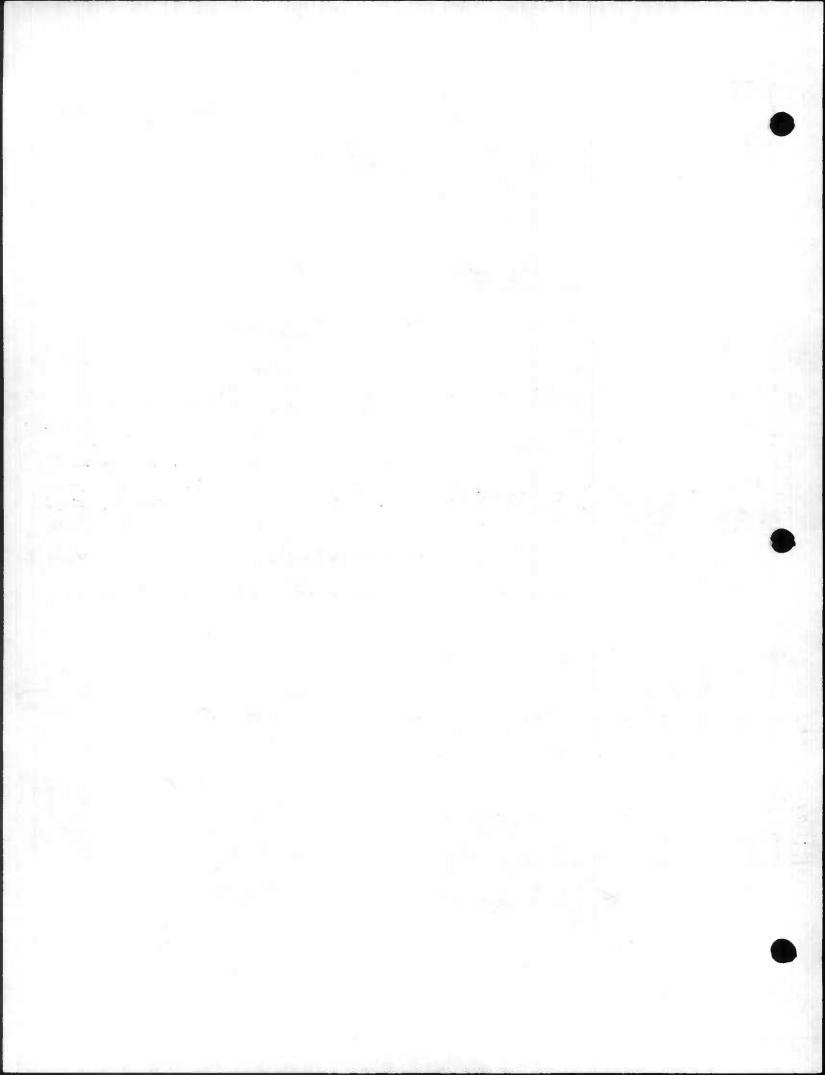
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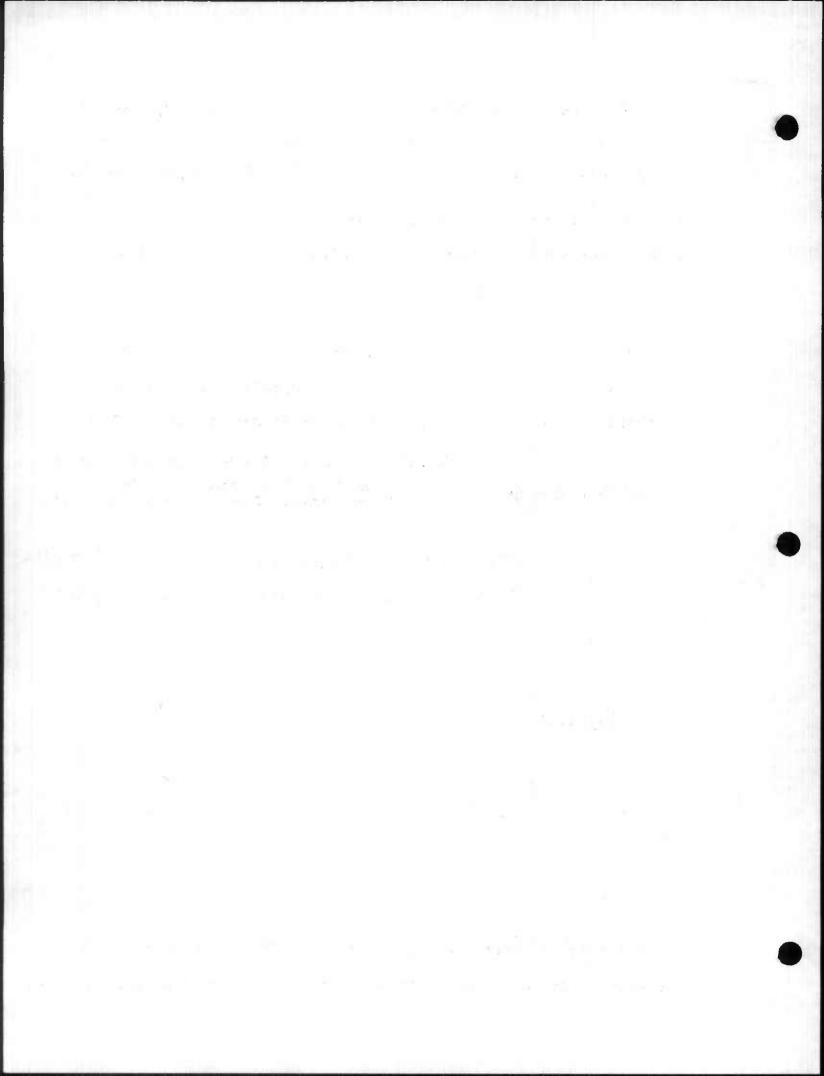
29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q

						Cert	ificate of	Death	Re	g. No.) 3	1914	
			1. Decedent's Nama (First, Middla, L.	ast)					2. Dete of Daati	1		3. Tima of Death	
	Physic /Medi		HAVEN ELI	ZABETH	HOFFM	AN			November	18, 1	999	11:35 P	M
	/iviedi Examii		4a. Facility Nama (If not institution, gi		110.111			4b. City, Town, or		4c. County			
7			Washington	County Ho	spita	1		Hagers	town	Was	hing	ton	
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	or 28	Olre	10e. Street and Numbar				10f. Zip Coda		10	g. Citizan of V	What Count	ry?	
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a	s me		19a. Informant's Name/Relationship	(Type, Print)	19b	Mailing	Addrass (Street	and Number or Ru	ıral Routa Number,	City or Town,	Stata, Zip	Coda)	
Z	alth 27 I		Robert C. Ve	eil Jr.	2	Pub	lic Squa	are, Hage	erstown, l	Marylar	nd 217	740	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Deportment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natur any Injury or other traumatic event, the Medical ORCE.		20a. Mathod of Disposition 1 □ curial 2 □ Cramation 3 [4 □ Donation 5 □ Othar (Space		camata	ry, crama	tion (Nema of atory or other place on Cemet	*	Date 2 1-23-99 H	Oc. Location -			
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68760,	cian	画	Sequentially list conditions, if any, leading to immediate ceuse. Entar Undarlying Cause (Disaasa or injury	C.									
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	irs el ral D												
	To the Hospital or Attending Phymin 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Cartifying Pl	nyelclan: To the best of miner: On tha basis of a end mennar state	xamination and	dor inva	occurred at the tir stigation, in my o	me, date and place opinion, daath occu	, end due to the ce rrad at tha tima, da	use(s) end me te and place,	ennar as st end due to	ated. the ceuse(s)	
	Withii To th	×	29b. Signature and titla of certifiar		_		29c. Licans	sa number	29	d. Date signe	d (Month, L	Dey, Year)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 3. Time of Death Yaar 8:55 Pm Roger Lee Haupt NOV 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 6. Sex 1⁄∆ M 2□ F If Under 24 Hrs. 8. Date of Birth Pay, Year) 7 Peb. 22, 1932 5. Social Security Number If Under 1 Year 7. Aga (In yrs. last birthday) 9. Birthplaca (Stete or Foreign Days Months Marilland 214-30-2092 67 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Md. Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21523 National Pike 21713 U.S.A 12. Was Decedant Evar in U.S. Armed Forces?

1/1 Yes 2 No
1/1 Yes, Give
1/2 Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Utility Co. Lineman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Carlton Ellsworth Haupt Sr. Elizabeth Rebecca Lum 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21523 National Pike Boonsboro, Md. 21713 June Haupt (Wife) 20b. Place of Disposition (Nema of cematary, crametory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State atary, crametory or other piece) Lena Cemetery Nov. 20, 1999 1 Burial 2 Cremation 3 Re Mt. Lena. Md. on 5 Other (Speci 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home ennis Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death netastati In Immediate Cause (Final manths disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of

Examiner Records, Division of Vital After

Examiner Physician/Medical by Completed or Attending Physician: Be edical Certification: To To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

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"natural", or flams 23a or 28a-f

pernit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiens. Important: If item 27 is merited other than "early injury or other true."

Director

Funeral

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Completed

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25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of cartiful

29c. License number

29d. Date signed (Month, Day, Year)

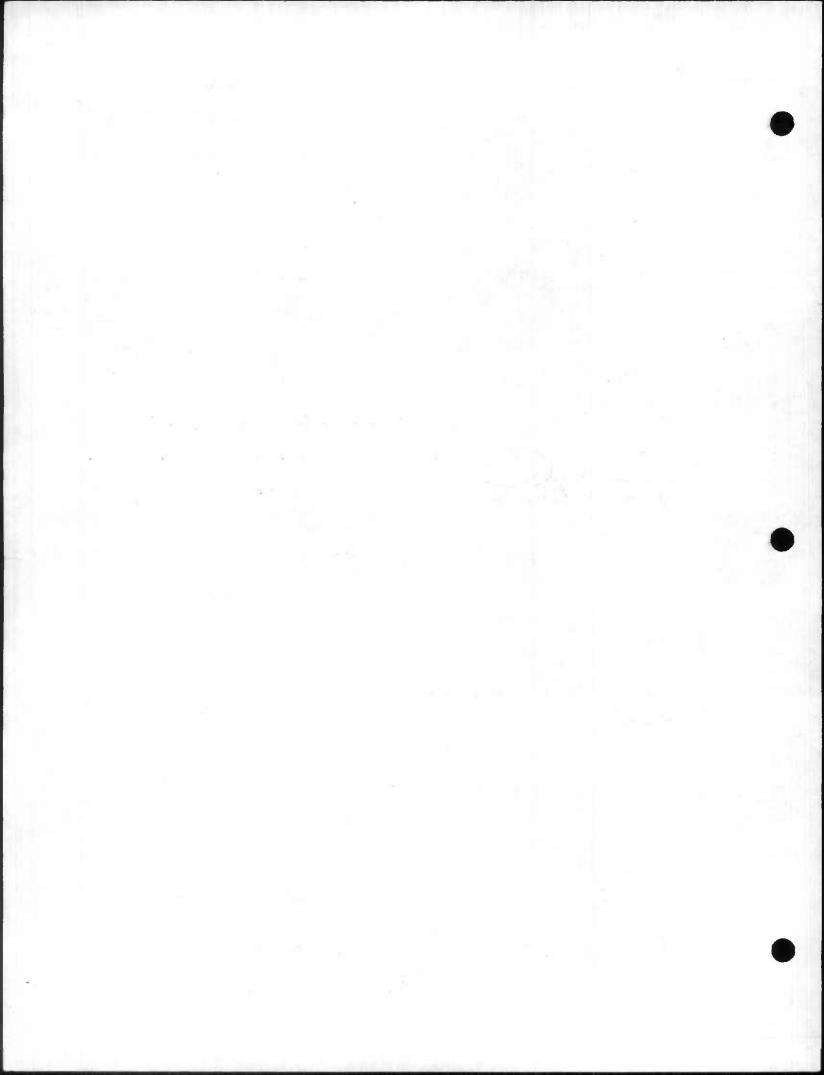
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vel

Hogertan

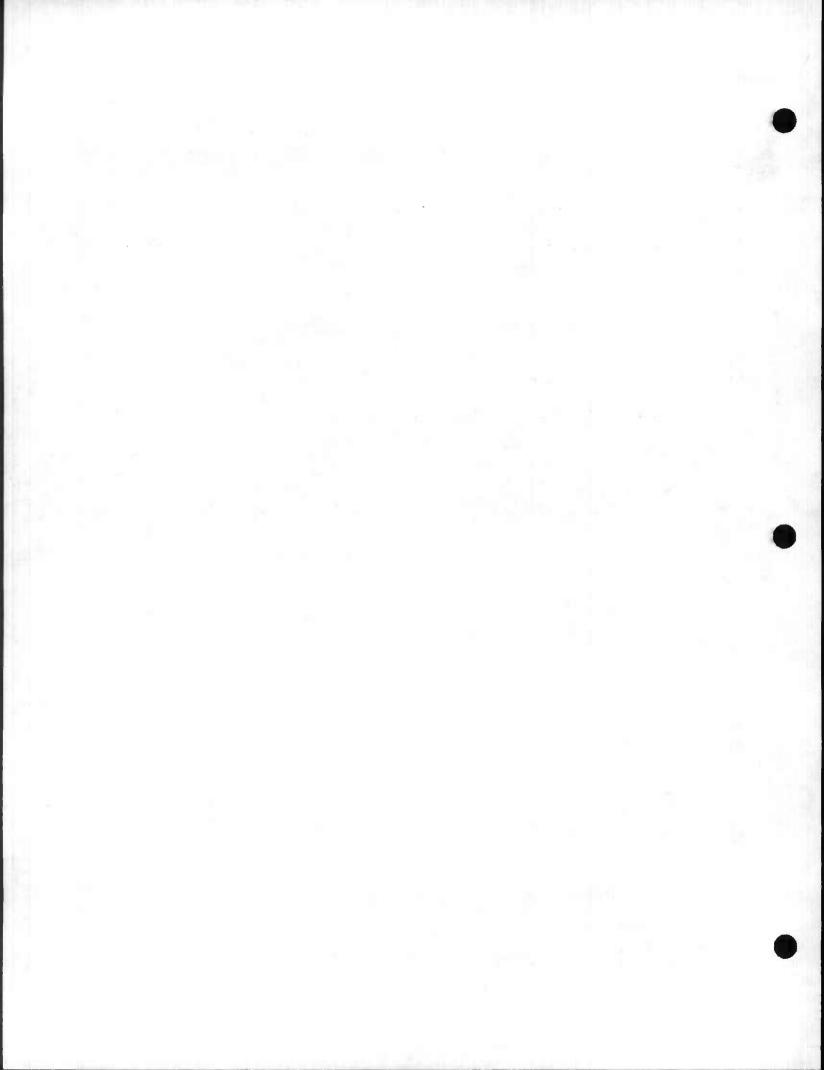
State Registrar

9 1999

32. Registrar's Signatura



hysician	Decedent's Neme (First, Middle, La Donald	william HAW	TK S			2. Deta of Deal Month Novembe	Day, Ye	3. Time of Death	
/Medical xaminer	al Ch. Thurstell								
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neral ector	219-34-5710	Sex 7. Aga (h	n <i>yrs. last birthda</i> 60 Yrs.	y) If Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth Month, Day July 20	, 1939 M	Birthplaca (State or Fore Country) [aryland	
or there 23e or 28e-f show aminer must be notified at y Funeral Director	Usuat Rasidance of Decedant 10a. State 10b. County		Oc. City, Town or					10d. Insida City Limi	
	Maryland Washing	ton	Hagerst	own		11/2		P∰Yas 2□!	
at be no	10e. Street and Number 10 West Side A	venue		10f. Zip Code 21	740	1	0g. Citizen of What U.S.A	Country?	
D D	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yas 2 No If Yes, Give Yaar or Datas:	r in U,S. 13	3. Was Decedent of Hi If Yas, specify Cuba 1 ☐ Yas 2 ☑ No	spanic Origin? (Sp n, Maxican, Puarto Specify:	ecify Yes or No- Rican, atc.)		marican Indian, /hita, atc. white	
event, the Medical De Completed	15. Decedent's E (Specify only highest gr.	ducation ada completed) Collega (1-4or 5+)	16a. Dec (Gir life	cedent's Usual Occupi va kind of work done o DO NOT use retired	ation furing most of works)	ing	16b. Kind of Busine		
Com	0-8	0	1:	aborer				y roads	
27 is marked other r traumatic event. To Be C	17. Fathar's Nama (First, Middla, Last Leslie C				18. Mother's Name	Ethel	Maiden Sumama) Hawbake	r	
	19a. Informant's Neme/Relationship (Mrs. Patricia Du	nkin/daughte	19b. Me er 369	Woodpoint				e, Zip Code) land 21740	
y or other	20e. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Special	Ramoval from Stata	20b. Plece of Dis	position (Nama of rematory or other plac ven Cemete		Nov.	20c. Location - City	or Town, State	
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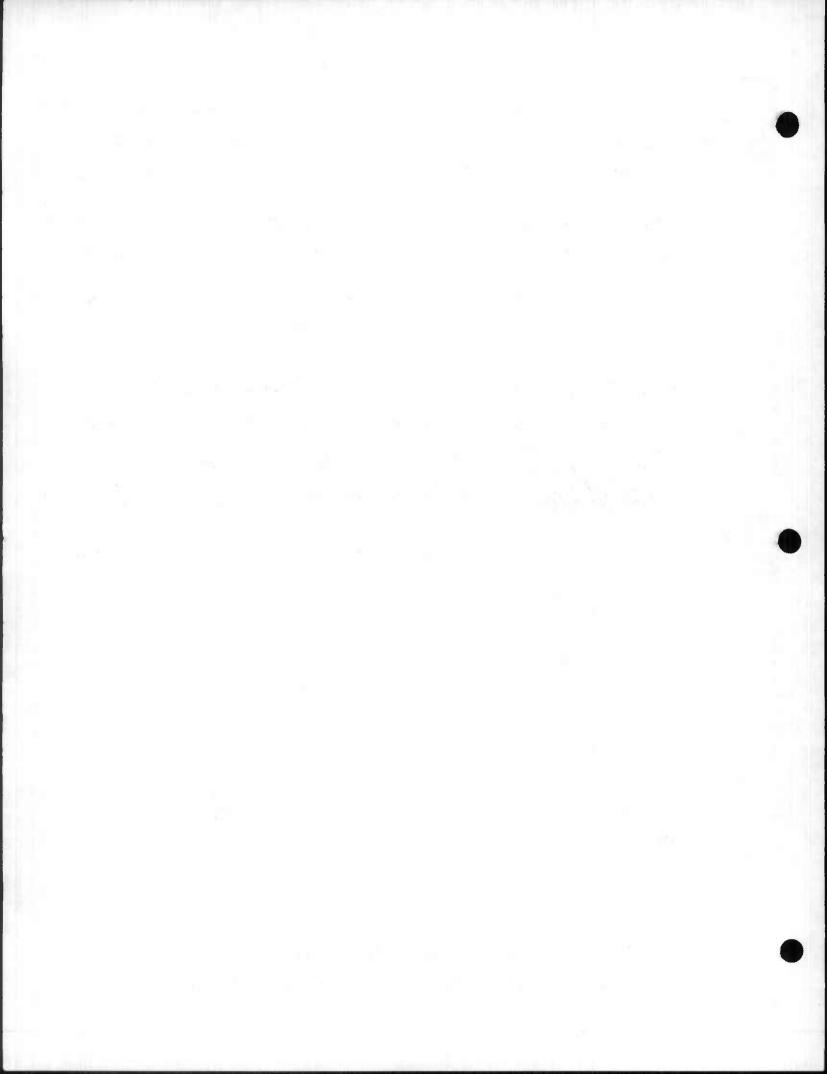


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Daath 3. Time of Death Month **Physician** EDITH (NMN) NOVEMBER 1999 HENNING 13 8:37 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6123 MOSER ROAD BOONSBORO WASHINGTON if Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Yrs 577-92-8942 Director JUNE 18, 1928 GERMANY Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or frams 23e or 28a-f show traumatic event, the Medical Examinor must be notified at 1 ☐ Yes 2 No Directo MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of Whai Country? 6123 MOSER ROAD 21713 GERMANY death Funeral 12. Was Decedant Evar in U,S. Armed Forces? 11. Mariial Status Was Decedeni of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "naturelt, or item eny injury or other traumatic event, the Madical Exerctions. 1 ☐ Never Married 2 X Married 1 ☐ Yas 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 □ Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY CHURCH 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WILHELM (UMN) DZIENIAN 2 THERESE (UMN) DZUBIEL 19a. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RUDI H. HENNING/SPOUSE 6123 MOSER ROAD, BOONSBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 11/16/99 BOONSBORO, MARYLAND 21. Signature of meral Service Licenses 22. Name and Address of Facility 7606 Old national Pike Paul M. Dean BAST FUNERAL HOME au Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rasplratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsat and Death Physician arcinoma /Medical Immediate Cause (Final ye our disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ician and bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Causa (Disease or injury that initiated events.) Due to (or as a consequence of): physician the bunal Box 68760 Physician/Medicai thet initieted events resulting in death) Last Due to (or as a consequence of): ettanding ed by the ettar detached for u Pert il. Other significant conditiona contributing to deeth but not resulting in the underlying cause given in Part i. PO 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 Yes 2 100 3 Probably 4 Unknown Division of Vital Records. by Completed 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 20 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Piece of Death (Check ogly one) examiner' Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Homa 2 1 ☐ inpatient 2 ☐ ER/Outpailent 3 ☐ DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. injury at Work? Natural 5 Pending 1 Tyes 2 No 2 Accideni investigation 6 Could not be determined 3 Sulcide 28f. Locailon (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. Medical 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Hamdan, M.D. 363 S. Cleveland Ave., Hagerstown, MD 21740 31. Date filed (Month, Day, Year) NOV 15 1999 32. Registrar's Signatura State Registrar



1. Decedent's Nama (First, Middle, Last)

Physician /Medical **Examiner**

Day Month Year Sarah Cassatt HERRMANN 1813 NOVEMBER 13, 1999 4a Facility Nama (Il not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dev. Year) Pennsylvania
Peb. 20, 1917 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🖾 F 82 Yrs. 219-66-2088 Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ¥ Yas 2 No Maryland Washington Hagerstown Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or flams 23s or must be 1319 The Terrace 21742 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Biack, Whita, atc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 72 hours after 1 Nevar Married 2 Married Specify: White altimore. Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglere. Elementary/Secondary (0-12) College (1-4or 5+) homemaker 0 - 12her own home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked of Neely George Maude Maxel1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1319 The Terrace, Hagerstown, Maryland 21742 Mr. Phillip A. Herrmann/husband 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Nov. 1 Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 16,1999 Hagerstown, Maryland 21. Signature of Funaral Service Licenses Minnich Funeral Home Nama and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Edema with Cardio fol merany over ? /Medical Immediata Cause (Final 4 Imonay disaasa or condition resulting in death) Examiner leviosilevotic Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 980 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yaa 251 certificata Vital 25. Was case refarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas / 2 No 1 | Inpatient Certification: To 2 ER/Outpatient 3 DOA of this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Division 1 Natural 1 Yes 2 No death. 2 Accident Director 6 ☐ Could not be within 24 hours after de. To the Funeral Directo completely filled in by th 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 Hospital 29a. Certifier edical 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. iner: On the basis of axar and manner stated. (Check only one) nination and/or investigation, in my opinion, death occurred at the time, data and place, and due to tha causa(s) within 2 29d. Data signed (Month, Day, Year) (overuber 31. Data filed (Month, Day, Year) 16 NOV Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death

2. Data of Death

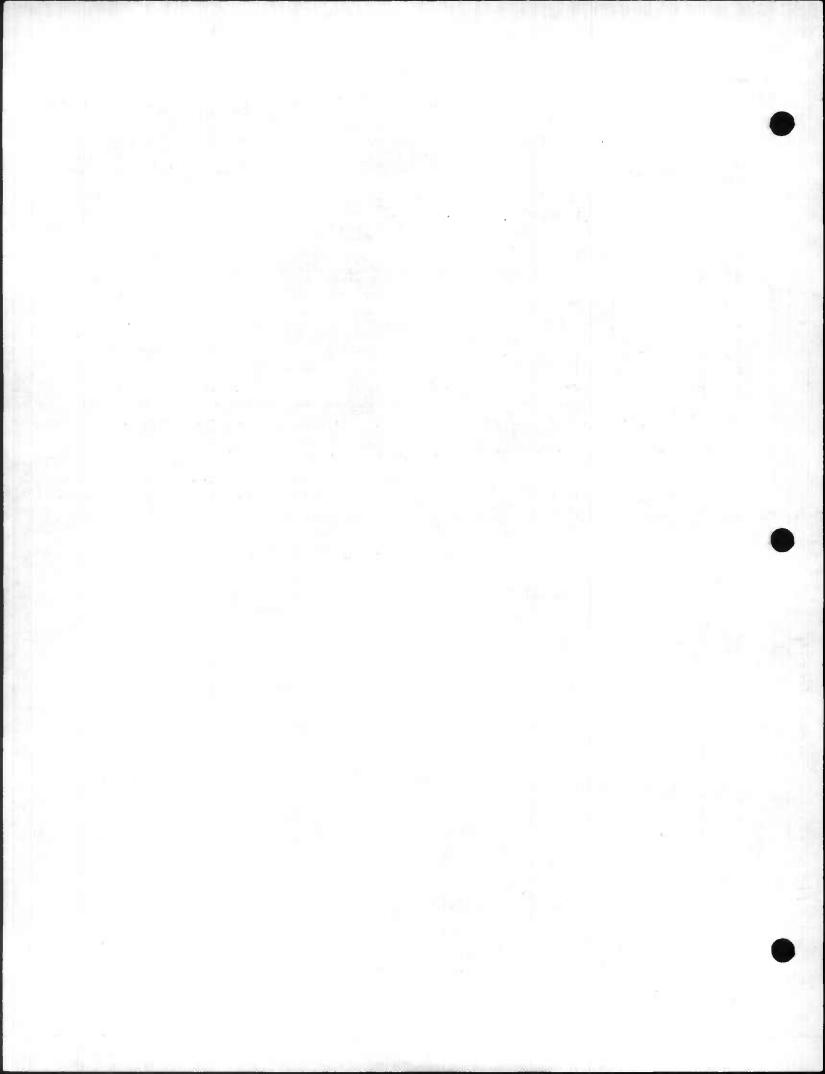
3. Tima of Death

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death / Month ber SACKSOOL EDWIN DWIGHT 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth HUnder 24 Hrs. 8. Dete of Birth Month, Day Year, August 12, 1964 PHINCE Georges HUS Attal Communita xx tous 9. Birthplece (Stelle or Foreign Country)
Washington, D.C. 7. Age (yrs. last birthday) 5. Social Security Number If Under 1 Year 1 Days Months 1X M 2 F 218-90-1997 35 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Landover 1 Yes 2 No 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 806 Heron Court 20785 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Giva 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Landscaper Private 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Colie Jackson, Jr. Emma McDaniel 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma D. Jackson/Mother 806 Heron Court, Landover, Maryland 20785 20b. Place of Disposition (Name of camelery, crematory or other place) Gardens 11/20 Forest Hills Memorial 1999 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funarel Service Licensee 22. Name end Address of Facility
J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Encephalitis tmmediete Cause (Finel disease or condition resulting in death) Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events resulting in deeth) Last Due to (or as a consequence of): Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown umouro 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

Examiner The law requires that the death certificate be executed Box 68760. P.O. Records, of Vital Physician: this After Division or Attending r death. 24 hours after deat Funeral Director:

Examine completely

Physician

/Medical

Examiner

Director

Funeral

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Pages 1 and 2 should be nent of Health and Mental

Physician

/Medical

aftimore,

Euneral

Director

Physician/Medical à Completed Be Certification: To Medical

2 Accident 3 ☐ Suicide 4 Homicide 29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29c. License number

Center Datue gutte 202, Greenhelt, Mis 20770

29d. Date signed (Month, Dey, Year)

525 Greenway 31. Data filed (Month, Day, Year)

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3 Registrar's Signature

Physician

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State

Registrar

within 2 å

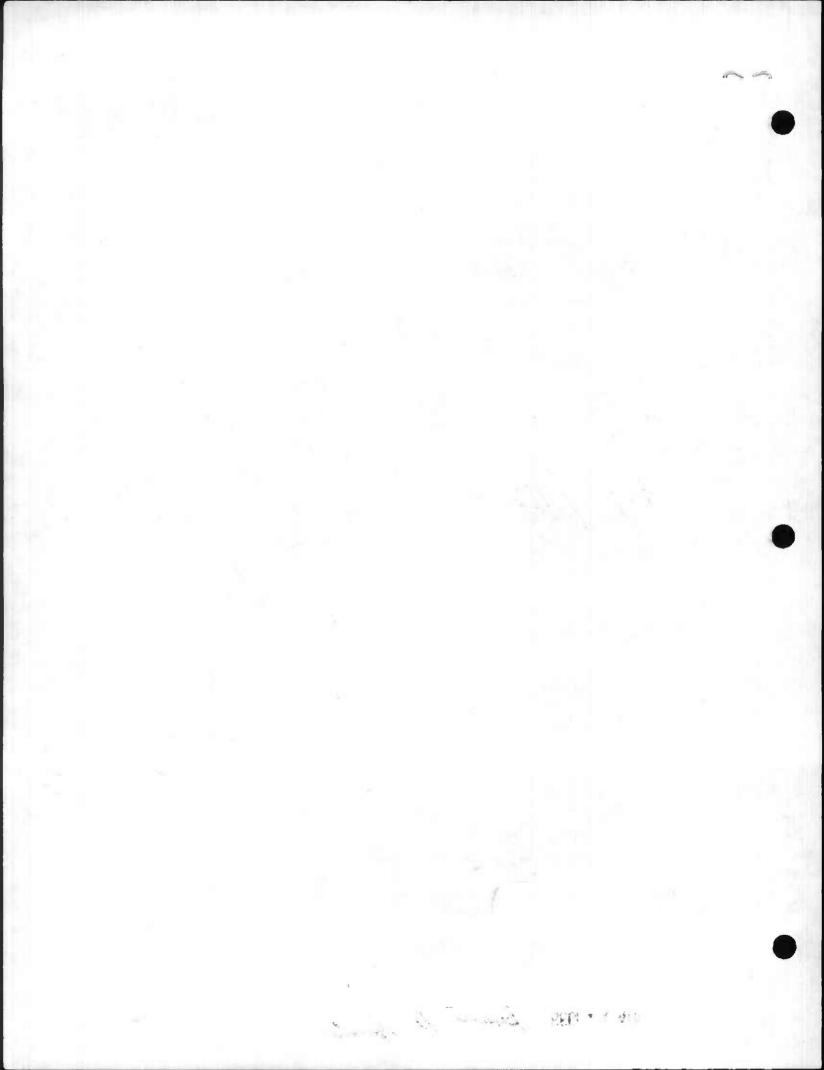
127 2 8 1939 Seems A. Jane

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death 1. Decedent's Nama (First, Middla, Last)	Reg. No.	37920
Physician	William Thomas Jackson	Month Day Year November1, 1999	3. Time of Death 0 9:48 mm
/Medical Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		
	Blue Point Nursing Home Baltimor	e Baltin	more
Funeral Director	5. Sociaf Security Number 6. Sax 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	B. Date of Birth (Month, Day, Year) 9. Bir C. Feb 21, 1928	nthplaca (State or Foreign ountry) Virgini
Maryland of show fied at	10a. State 10b. County 10c. City, Town or Location Baltimore		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
h with the Mar 38 or 28s-f al at be notified	10e. Street and Number 10f. Zip Code 21206	10g. Citizen of What Co	ountry?
d 21215-0020 filed within 72 hours after death with the Maryland hygient than "natural", or frems 23s or 28s-1 show ont, the Medical Examination must be notified as Completed by Funeral Director	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedant Evar in U,S. Armed Forcas? 1 □ Yes 2 ☑ No If Yas, specify Cuban, Mexican, Puerto I 1 □ Yes 2 ☑ No Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puerto I 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No Specify:	city Yea or No- Rican, etc.) 14. Race - Am Bleck, Whi Specify: B1	te, etc.
ed within 72 ho ygiene. er than "naturi t, ma Wedical.	15. Decedent's Education (Specify only highast grade complated) (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business	/Industry
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yland 212 build be filed with Mental Hygiene. arked other than atic event, the Hygiene. To Be Commit		(First, Middle, Maiden Surnama)	
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Baltimore, Semit. Pages 1 at Department of Hea moortant: if Item; any injury or othe	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or 8,1999 Charlot	
Baltir permit. P Departme Importan any foliur once.		illiam Funeral harlottesville	
Physician /Medical Examiner	Immediate Cause (Final disease) for complications that caused the death. Do not enter the mode of dying, such as cardiac of the cause on each line. Immediate Cause (Final disease or condition rasulting in death) Due to (or as a consequence of):		Approximete Interval Between Onset and Death
Box 68760, sub certificate be executed attending physician and for use as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enlar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): C. Dua to (or as a consequenca of): d.		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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P.O. date the date of between Phys	PVD	1 Yes 2 No 3 Probably 4 t	
The law requires that the death cert has been signed by the attending page 2 should be detached for use a Completed by Physician/M		24a. Was an autopsy performed?	Were eutopsy findings available prior to completion of cause of death?
I Rec The law ate has b page 2 s		1 Yes 2 No	1□ Yas 2₽No
Vital Fidelen: The certificate rector, pag	25. Was case referred to medical according to the same series of Death	(Check only one)	
- 2 00	1 ☐ Yes 2 ☒ Ø/6 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 🗶 Nursing Hor	me 5 Residence 8 Other (Spe	ecity)
Division or To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	Month, Day Year) Injury Work? 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
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Ne Hospital n 24 hours in Ne Furneral pletely filled	29a. Certifier (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, a construction one)	and due to the cause(s) and manner a ed at the time, date and place, and du	is stated. le to the cause(s)
within To the comple	29b. Signature and title of certified M 29c. License number D 2756 4	29d. Date signed (Mon	
(3)	30. Name and address of person Algocompleted cause of death (Item 23e) (Type, Print) All All Linus 1834 Steine Twe Rd	#300	1
State Registrar	31. Data filed (Month, Day, Year) 32. Registrar's Signature	/00	
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Physician	THURY LARNELL TALKSON						ER 21 1	Year 999	0530 AM
/Medical Examiner	4a Facility Name (If not institution SOUTHERN MARY)	, give street and number)			4b. City, Town, or L CLINTON		4c. County	-	
Funeral Director	5. Social Security Number 140–48–1889	6. Sex 1 □ M 2 ☑ F	(In yrs. last birthda) 45 Yrs.	Months Day		8. Date of Birth (Month, Day 09-22-	(egr)		ce (State or Foreign
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od within 72 ho yglene. or than "naturi ft, the Madeel Completed	15. Decedent (Specify only highes	s Education	16a. Dec	edent's Usual Occ	upation e during most of work	kina	16b. Kind of Bu	siness/Indus	stry
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permit. Pages 'Department of F Important: if the eny Injury or of once.	12.1	TVH ~	// //		ntown Rd,				748
	you a	organications that caused							
	23a. Part 1. Enter the disease, or shock, or heart failure. List	only one cause on each ten	e. CARDIAC	ARRHYTHMIA	IN ASSOCIAT	ION WITH L	EFT	i In	pproximete nterval Between Inset end Death
Physician /Medical	Immediate Cause (Final				DRONARY ATHER	ROSCLEROSI	S		nisor one count
Examiner	disease or condition resulting in death)	a. DURING	G THERAPY FO	OR EPISTAXI	S				
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2 2 2	27. Manner of Death	28a. Date of Injury		of 28c. Inj		28d. Describe h			
or death. ector: After by the fune lification	1 Netural 5 Pending		reary more		Yes 2KNo				
after death Director: A d in by the fi	3 Suicide 6 Could n 4 Homlcide determi	ot be ned 28e. Place of Inju	ry - At home, lerm, a	street, lectory, office	Э	28f. Location (Si City or Town	reet and Numb	er or Rural F	loμ(ρ,N umber
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	1 X W	11 lanes	Y.JVI.) o.c	.M.E	1	NOVEMBE!	R 23,1	.999
(10)	30. Name and address of person v	tho completed cause of de	eth (Item 23a) (Type	e. Print)					
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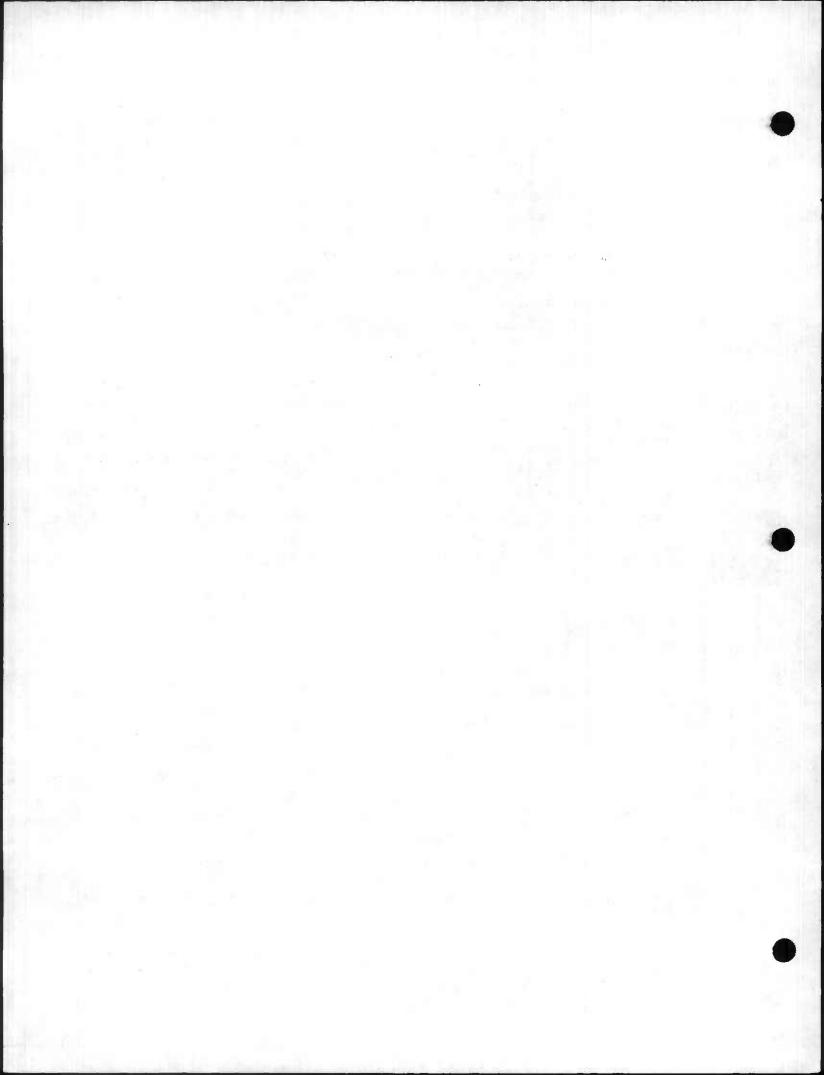
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 18,1999 Louise Anna Jones 10:35 am /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1800 Harpers Ferry Road Knoxville Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 206-10-6155 83 Yrs. Director June 29, 1916 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show Washington Knoxville 1 Yes 2 No Maryland Directo thems 23s or 28s-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21758 USA 1800 Harpers Ferry Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 Yas 2 No
If Yes, Give
Yaer or Datas: 1 ☐ Nevar Merried 2 ☐ Merried natural', or altimore, Maryland 21215-0020 1 Yes 2 No Specify: à Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Housewife Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg-trrportant: if them 27 is merked other any Injury or other trausment other once. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Maschal Fannie Nicholls Benjamin 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn C. Maize/Daughter 1800 Harpers Ferry Road Knoxville, MD 21758 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Smithsburg Crematory Nov. 19, 1999 Smithsburg, Maryland 21. Signeture of Funeral Service Licensae 22, Name and Address of Fecility 425 S.Conococheague S Williamsport,MD 21795 Osborne Funeral Home 0 23a. Part Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellipse. List only one cause on each line. Physician /Medical Immediete Cause (Final Probable disaasa or condition resulting in deeth) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Dua to (or es a consequence of) esn 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. P.O. Yes 2 No 3 Probably 4 Unknown by P S 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 1 Yes 28 No 1 ☐ Yes > No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Netural 5 Pending Invastigetion a 24 hours after death.

• Funeral Director: After detely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicida 28a. Plece of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. edicai To the Hosp within 24 ho. To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Molina MD Michael Jolino, M.D. 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Suite Frederict Aue 204 1475 Taney 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year)

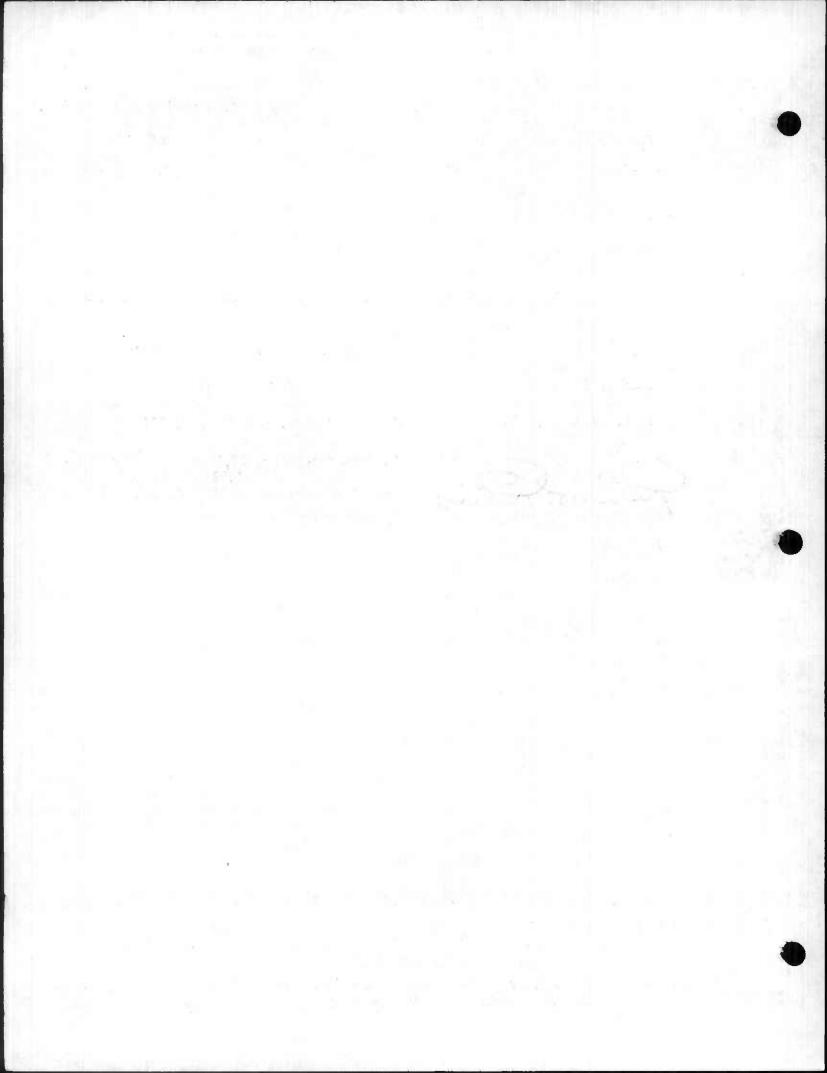
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State of Maryland / Department of Health and Mental Hygiene 9 9 37923

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Physic	ian	1. Decedent's Name (First, Middla						2. Dete of De	ath	Yes	3. Tima of D
/Medi		Terry Lee Jo		Month November 1					1999	2:15	
Exami	ner	4a. Facility Name (If not institution,						Location of Deati			
		Atlantic Gen				4	Berl			cester	
Funerai lirector		212-38-9864	6. Sax 7. Age 1 M 2 □ F	(In yrs. last bit	Yrs. If Un Month	hs Days	If Under 24 Hr Hours Mir		1, Year) 3, 1941	9. Birthple Country Mary	ica (State or I
WO III		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10	d. Insida City
28a-fa	ector	Del. Susse	X	Dags							1 ☐ Yas 2
23a or 3	Funeral Director	3 Nanticoke La	ne		10f.	79939	9		10g. Citizen of	What Countr S.A.	y?
ita hygiene. d other than "natural", or itams 23a or 28a-f ahow event, tra Madical Examber must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ev Ammed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:			ecedent of H specify Cuba s 2 No	Hspanic Origin? (an, Mexican, Pue Specify:	Specify Yas or No rto Rican, atc.)	14. Rad Bla Specif	Race - American Indian, Black, White, etc. ecity: White	
natu	leted	15. Decadent' (Specify only highast	s Education grade completad)	16a	Decedent's U	sual Occup work done	pation during most of wo	orking	16b. Kind of B	usiness/Indu	ıstry
na Mental hyglene. marked other than imatic event, tre M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			n Engin		Cons	struct	ion
vent,	Be	17. Father's Name (First, Middle, L	*	· ',			18. Mother's Na	ma (First, Middle,	Maiden Suman	n <i>e)</i>	
arked arked	To	Harold L. Jon	es				Hilda	a Mae Sho	ank		
5 00 2		19a. Informant's Neme/Relationsh						iural Route Numbe			Code)
		Terry L. Jones	Jr. (Son)				wn Ct. 1	Pasadena,			
If Item 2 or other		20a. Method of Disposition 1 ☐ Burlai 2 ☐ Cremation	3 □Removal from State	camate	f Disposition (I	or othar plac	ce)	Date	20c. Location		
dury		4 Donation 5 Other (Spi	ecify)	Smith	sburg C	remat	tory Nov	, 17,19	99 Smu	thsbur	g,Md.
Important: If Item 2 any Injury or other once.		2. Signature o Funeral Sarvica U	A Nan				ss of Facility	12525 e Smith	Bradbw sburg, M		
-		23a. Part1. Enter the diseasa, or o	, ,		2 000.00		Jeur Hom	C OIII-CCIO			
iedicai		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting In death)	complications that caused the nity one cause on each line a. ACUTI	= M	not enter the m	node of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximata ntervel Betwe Onsat and De
ledicai aminer	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate causa. Enter Undarrying Ceuse (Disease or Injury that initiated events	a. Acuti	tue to (or as a due to (or as a d	not enter the m	node of dyin PD / / of):	ng, such as cardia	c or respiratory a	rrest,		Approximata
ledicai aminer	Medical	Immediate Cause (Final disease or condition resulting In death)	a. Acuti	tue to (or as a due to (or as a d	YO CAR	node of dyin PD / / of):	ng, such as cardia	c or respiratory a	rrest,		Approximata ntervel Betwe Onsat and De
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ad by the attending physician and detached for use as the bunal-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate causa. Enter Undarrying Ceuse (Disease or Injury that initiated events	a. Acutt	uue to (or as a due to (or as a d	not enter the man enter the ma	node of dyin PD// of):	ng, such as cardia	C or respiratory at	rrest,	Fig.	Approximata Intervel Between Drisat and De Cause of the c
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Director: After this certificate hes been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the bunal-transit of in by the funeral director, page 2 should be detached for use as the bunal-transit of in by the funeral director.	Tedical Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate causa. Enter Undartying Ceuse (Disease or Injury thet initiated events resulting in death) Last Part II. Other aignificant condition 25. Was case referred to medical examiner? Part II. Other aignificant condition 27. Menner of Death 1 Matural 5 Pending Investiga 1 Suicide 6 Could no determin 29a. Certifiar (Check only 2 Medical Examiner)	a. ACUTT b. AS C c. Du d. S contributing to death but Hospital: 1 Inpatient 28a. Date of Injury (Month, Day') tion t be ed 28e. Placa of Injury building, etc.	use to (or as a due to (or as	tpatient 3 treet, fact	DOA Other work of the time of time of the time of the time of time	an In Part I. 26. Plece of Deer: 4 Nursing It Yes 2 No	23b. Did to the curred at the time, of	cobacco usa co Yes 2 No an eutopsy rmed? Yes 2 Mo ne) lence 6 Oth now injury occur Street and Numb nn, State)	24b. Were avail common of de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximata Intervel Betwee Disast and De Cause of Cause
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** CHARLOTTE M. KADOW NOV. 17,1999 4:20 AM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY CO. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 25 F 134-05-0737 90 Yrs. 9, 1909 CANADA Director MAY Usual Residence of Decedent the Maryland 10a State 10b. County r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY MD. ROCKVILLE Director X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11. Marital Sfatus 13. Wes Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indian, Black, White, etc. 72 hours after 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "na eny Injury or other traumatic event, the Maute page. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER AT HOME 12 17. Father's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumame) MERIT RAMEY ETHEL LEGGETT 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) JANET HONECKER- DAUGHTER 8344- WAGON WHEEL RD., ALEXANDRIA, VA.22309 20b. Plece of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State METROPOLITAN CREMATORY-11/18-ALEXANDRIA, VA. 21. Signature of Funeral Service Lipensee 22. Name end Address of Facility HYSONG CO., INC. FUNERAL HOME 1300- N STREET, NW, WASH., DC 23a. Part1. Enter the disease, or co shock, or heart failure. List on Approximete interval Between Onset end Death ations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, a cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) mon Examiner a consequence of): Examiner physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequenca of) P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the updertying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown Records, signe bed Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed' page 2 1 Yes 2 No certificete 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physicien:
 24 hours efter death.
 Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending Investigation 2 Accident 1 Yes 2 No the To the Hospital or Attaining 24 hours after dea To the Funeral Director completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as steted. Ical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated. B 29b. Signature and title of cartified 29c. License number 29d. Date signed (Month, Day, Yeer) Klereth 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) KARESH - 9701- VEIRS DR., ROCKVILLE, MD. 20850 CHARLES W.

Registrar

32. Registrar's Signature

31. Date filed (Month, Day, Year, NOV 1 9 1999

HOV 1 9 1939 Some A. South

State of Maryland / Department of Health and Mental Hygiene

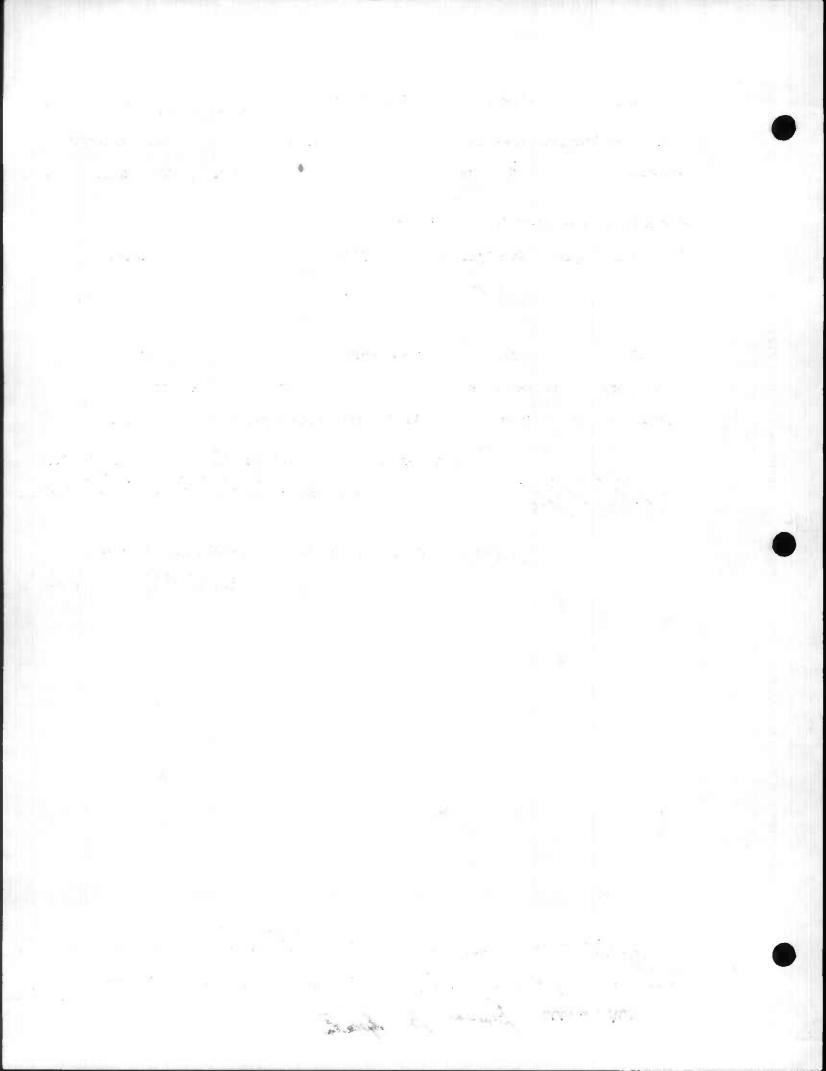
37925 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Dey Month Physician 12, Walter 1999 Kulchycky Nov. 7:57 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel H Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 07-19-1920 Director 79 Ukraine 052-26-3527 **Usual Residence of Decedent** the Menyland 10a State worle 10b. County 10c. City. Town or Location 10d. Inside City Limits than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Gambrills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2053 Liza Way 21054 USA 12 Was Decedent Ever in U.S. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural, or Item any Injury or other treumatic event, the Head of Emmande Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Librarian Public Library 6 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) å Gabriel Kulchycky Maria Kulchycky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ksenia Kulchycky/Daughter 2053 Liza Way Gambrills, Md. 21054 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Memovel from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Spirit Cem. 11+16-99 Washingtonville, NY 21. Signature of Fyneral Service Licensee 22. Name end Address of Fecility Shannon W. Beall M00798 Beall Funeral Home 6512 N.W. Crain Highway Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** ymphoma Immediate Cause (Final disease or condition resulting in death) 3MOS. /Medical Examiner Due to (or as a consequence of) Examiner physicien end the burief-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2000 18019 longstanding 3 Probably 4 Unknown be det à 24b. Were autopsy findings eveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 2000 1 Yes 2 No Division of Vital or Attending Physician; 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 After thi 27. Manner of De 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 ANatural 2 Accident 5 Pending 1 Yes 2 No deeth. investigation Director: / 6 ☐ Could not be determined To the Hospital or Atte within 24 hours after da To the Funeral Directo completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 019838 29b. Signature and little of pertities 29d. Date signed (Month, Dey, Year) 14850 11-12-99 Bestgate Rd. Annapolis, Und 21401 selounkus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Stuart E. Selonicu, u.o. 900 31. Date filed (Month, Day, Year) 32 Registrar's Signeture State NOV 17 1999 Registrar

		State of Mary		rtificate of		F	Reg. No.	01520
Physician	Decedent's Name (First, Middle, Last Althea	Rebecca	Ka	arschner		2. Date of Dea Month Novembe:	Day	Year 10:21PM
/Medical Examiner	4e Facility Neme (If not institution, give	street end number)			4b. City, Town, or L			
	Southern Marylan	d Hospital			Clinton		Prince	George's
Funeral	Social Security Number 6. Se		yrs. last birthday	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h (Year)	Birthplace (State or Foreign Country)
Director	217-34-2195 Usual Residence of Decedent	□M 2XF 92	Yrs.			Aug. 8		Hughsville, PA
ahow alow	10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
vith the Meryla tor 28a-f ahor be notified.	Maryland Prince Ge	eorge's	Clinton			1.	10a Citizan of Mi	1 Yes 2 No
Vith Vith			64.2	10f. Zip Code			10g. Citizen of W	
seth w	8600 Mike Shapiro	Drive Apt. 12. Wes Decedent Ever		20735	dispanic Origin? (Sp	ecify Ves or No-	U.S	- A American Indian,
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Meryland th end Menlel Hygiene. 7 is marked other than "natural; or items 23s or 28s-1 show traumatic avent, the Medical Exemples rough	Widowed 4 □ Divorced	Armed Forces? 1 Yes 20000 If Yes, Give Year or Dates:	13.	If Yes, specify Cub 1□ Yes 2√2 No	Hispanic Origin? (Spean, Mexicen, Puerto Specify:	Ricen, etc.)	Black Specify:	White, etc.
1 21215-003 ed within 72 hours ygiene. ner than "natural; rt, me Modical Exi	15. Decedent's Edu (Specify only highest grad	ucetion de completed)	16e. Dece (Give	edent's Usual Occup e kind of work done	pation during most of work od)	ing	16b. Kind of Bus	siness/Industry
2121 3 within jiene. T than "	Elementary/Secondary (0-12)	College (1-4or 5+)			od)			
a filed withing the Hygiene. Other than vent, max.	17. Father's Name (First, Middle, Last)	N/A	Home	emaker	18. Mother's Nam	e (First Middle	Maiden Sumame	
ylanc ould be fil Mentel H marked oth martic aven To Be		useknecht					drews	,
larylar 2 should be and Mente is marked sumatic av	19a. Informent's Name/Reletionship (7)		19b. Mail	ing Address (Street	Maggie			State, Zio Code)
C - M L	Arnold Karschner				Lane Free			
or other tr	20a. Method of Disposition	2	Ob. Place of Disp		T	Dafe		City or Town, State
Saltimore, semit. Pages 1 er Separtment of Hearmontant: If Item; my Inlury or other	1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		ee Crema		Novemb	ar 1999	Clint	on, Maryland
Baltimo	21. Signature of The Artegrace Licens	-		2. Name end Addre			ral Home	
	1/////		(6633 Old				inton, MD20735
	23a. Part1. Enter the disease of composhock, or heart failure. List only o	lications that ceused the	death. Do not er	nfer the mode of dyi	ng, such as cerdiac	or respiretory ar	rest,	Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final diseese or condition resulting in deeth)	ANDE			-			Onset and Death
in d		Due	to (or as a conse	equence of):		D (SE)	SZAS	YEARS
60, be executed telan and buriel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	Due	to (or as a conse	equence of):				
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= 00 =	The state of the s	d.						
for for a		. %	101		- I B	one Did		tribute to the cause of death?
at the de d by the eteched	Part II. Other eignificant conditions con	ntributing to death but no	ot resulting in the	underlying cause gr	ven in Pert I.			3 Probably 4 Unknow
							295110	
requirements						24a. Was perfo	an autopsy rmed?	24b. Were autopsy findings available prior fo completion of cause of deeth?
						101	res 2 No	1 ☐ Yes 2 ☐ No
ysicien: The ysicien: The is certificate director, pag	25. Wes cese referred to medical examiner?				26. Place of Dear	th (Check only o	ne)	
_ Z 25	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpetie	ent 3LI DOA		ome 5 🗆 Resid	dence 6 Othe	r (Specify)
on of offing Plan.	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time Injury	Wo		28d. Describe h	now injury occurre	ed
Attending or deeth. actor: Afte by the fune	2 Accident investigetion 3 Suicide 6 Could not be				Yes 2 No	Oof Leasting #	Dans ad a seed file on he	er or Rural Route Number,
DIVISION OT LIST OF Attending Physics efter death. at Director: After this led in by the funeral di Certification: To	4 Homicide determined	28e. Place of Injury - building, etc. (S		treet, factory, office		City or Tou	vn, State)	or nurse noute reuniber,
Hospi 24 hou Funer fely fill		sician: To the best of m lner: On the basis of exa and manner stafed	mination and/or i					
To the rethin To the comple	29b. Signature and title of certifier			29c. Licen	se number		29d. Defe signed	(Month, Day, Year)
(100		N	10-	-1859	S	Novem	RELIS, 199
0	Named and address of person who or	ompleted cause of death	(Item 23a) (Type	OCA C	INE C	EUTER	WAL	sorf, Md.
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	,				2.050
Registrar	NOV 1 7 1999	Sheva	1.	Sports	-			
DHMH 16 Rev 6/95		/	/	mount				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Maria Katis 13,1999 4:42am November /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 577-70-8615 74 Yrs. Feb.11,1925 Greece **Director** Usual Residence of Decedent worle 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Demit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinet must be notified at page. 1 Yes 2 No Md Montgomery Director Wheaton 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 11604 Elkin Street 20902 Greece Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last)
Thanasis Fous 18. Mother's Name (First, Middle, Maiden Sumeme) Be Fousekis Vasiliki Arapoyianis 10 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Katis/ Son 13005 Middlevale Lane Silver Spring, Md20906 20b. Plece of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetory or other place)
Gate of Heaven 1\(\) Burial 2 Cremation 3 Removel from Stete
4 Donation, 5 Other (Specify) 11/16/99 Silver Spring, Md. 21. Signature of Funeral Service Lice 22. Neme end Address of Facility Philip 11818 D.Rinaldi Funeral Service New Hampshire Ave.Silver Spring,Md male Approximate Interval Between Onset end Deeth 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel Carcinoma of the parotid gland disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Cerebral atherosclerosis physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Diabetis Millitus P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 88 been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the causs of death? 3 Probably 4 Unknown 1 Yss 2 No Records. þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Was an autopsy performed? page 2 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 24 hours after death.

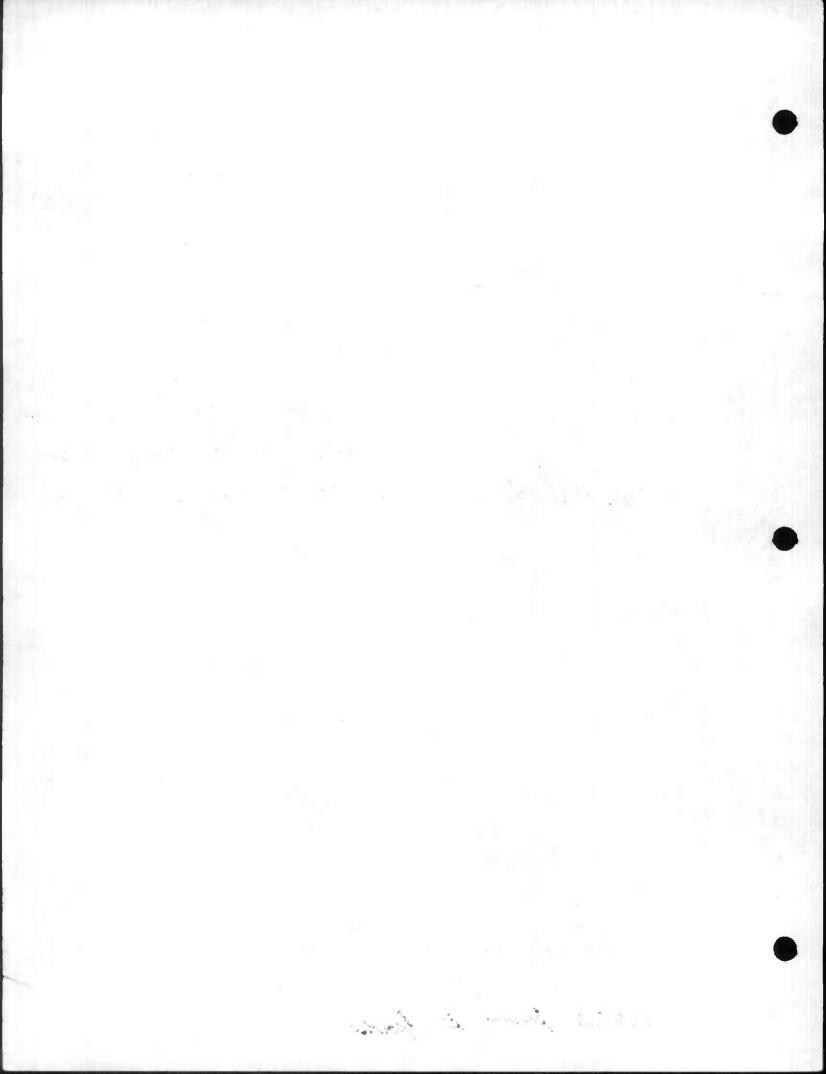
Funeret Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature end title/of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MD D27865 11/13/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mark K. Li, MD 1721 University Blvd. Wheaton, Md 20902

State Registrar

31. Date filed (Month, Dey, Year)

32. Registrar's Signeture ports



						ertificate			irontai i i j	Reg. No.	99 3	37928
Physic /Med		Decedent's Name (First, Middle, Last, MARGO		KIF	RKPAT	RICK			2. Dete of Do Month NOV EI	Dav	Year	Time of Death 4;30 A
Exam		4e. Facility Name (If not institution, give			LILLER	TO N	4b	. City, Town, or L		10.000		
		MANOR CARE HEAL 5. Social Security Number 6. Sec		7. Age (In yrs.			er	WHEAT If Under 24 Hrs.	9 Date of Bi	eth	TGOME	(State or Foreign
Funera Director			M ¾ C}√F	84	Yrs.	Months Da		Hours Min.	Jan.	28, 19	_ Country)	DDL' ISLA
yland		10a. Stefe 10b. County		10c. Ci	ty, Town or	Location					10d. ii	nside City Limits
Mar	to	MARYLAND MONTGO	MERY		TA	KOMA PAI	RK				1	Yes 2□No
or 28	Director	10e. Sfreet end Number				10f. Zip Coo	е			10g. Citizen of	Whet Country?	
23a	lai	6615-WESTMORELAND	AVEN	JE			20	912		UNITED	STATES	3
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Sfafus 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gir Year or D	2 No ve	J,S. 13	Was Decedent If Yes, specify (1 ☐ Yes 2 💥		panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	o- 14. Rad Bla Specifi	ck, Whife, etc.	
2 hou		15. Decedent's Edu		Ja 103.	16a. Dec	edent's Usual Oc	cupat	lon		16b. Kind of B	usiness/Industr	
d within 72 ho jiene. r then "netur	Completed	(Specify only highest grade	com <i>pleted)</i>		(Giv	e kind of work do DO NOT use re	ne du	iring most of work	ding	100.1410.010	danio danio dati	,
d with	E O	Elementary/Secondary (0-12) UNKNOWN	College (1-40r 5+)	ANIM	IAL HOSP:	CTA	L ASSIST	1	ANIMAI	HOSPIT	AL
ould be filed Mental Hygi erked other atic event, I	Bec	17. Fether's Name (First, Middle, Last)	-				1	18. Mothar's Nem	e (First, Middle	, Maiden Surnar	ne)	
should by a Menta	To	JOHN PE	RRY						AIVTO	VETTE OL	IVER	
and and and and and and and and and and	1	19a. Informant's Name/Relationship (Ty	pa, Print)		19b. Ma	ling Address (Str	eet ar	nd Number or Rui	al Route Numb	per, City or Town,	Stata, Zip Cod	e)
of Health if item 27 if other tr		MARTE DiGENNARD / 20a. Method of Disposition 12-8 urial 2 Cremation 3 CR		20b. F	Place of Disp	CASTLE position (Name of ematory or other		Y, SILVE	Data	20c. Location	City or Town,	
thmer duny		4 □ Donation 5 □ Other (Specify)				MEMORIA			1999		LLE, MA	RYLAND
permit. Pag Department Important: any Injury o		21. Signature of Funerei Service License		11	.)	22. Name and Ad 254	dress -CA	of Fecility TRROLL ST	'AKOMA I	FUNERAL WORTHWES	HOME T	
Physician /Medical Examiner	1	Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions,			or as a cons	equence of):	a	ncer				ef and Death
attending physician and for use as the burlat-transit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lasf		Due to (d	or es e conse	equence of):						
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icien: The lay certificata has rector, page 2									10	Yes 20 No	1 ☐ Yes	2 □ No
ysician: is certific director,	Be	25. Was cesa raferred to medicel examiner?	ospital:				Other	28. Place of Daal				
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withing to the property of the	Certification:	2 Accident investigation 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								(Street and Numl wn, State)	per or Rural Rou	ute Number,
24 hour Funera	edical (29a. Cartifier 1 Certifying Phys	er: On the ba	best of my kno asis of examina ner stated.	wledge, dea tion and/or l	th occurred at the	fime	, dete and place, nion, death occur	and due to the red at the time,	cause(s) and ma date and place,	anner as stated and dua fo the	Cause(s)
ithin o the	Mec	29b. Signeture and title of certifier	and man	ioi stateu.		29c. Lic	ense i	number		29d. Date signe	d (Month, Dav.	Year)
- 3 F 8		W, 00	roil	llan	10							
(2)		30. Nama and addrass of person who co	mpleted caus	se of death (Itan	n 23a) (Type	Print) Ro	ch	2518 cerus	Pin	E# 4	DI RI	100001C
	1	31. Date filed (Month, Day, Year)		legistrar's Signa	1	1 1						0.

No. 15 1935 James A property

State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 14,1999 **Physician** So1 Solomon Kluger 8:15 am /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c County of Death **Examiner** Hebrew Home of Greater Washington Rockville. Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 7, 1910 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√2 M 2□ F 89 Yrs. Germany Director 129-20-2322 Uauai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1. Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be r 20852 1801 East Jefferson St. Apt. 541 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1★1 Yea 2 □ No If Yes, Give Year or Dates: 1942 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent'a Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 73 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Dry Cleaner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father'a Neme (First, Middle, Last) Moses Kluger Rose Gottlieb 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 at Department of Health and Important: If them 27 is n any Injury or other traun once. Berta Kluger / Wife 1801 Jefferson St. Apt.541 Rockville, MD 20852 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State 11615 D.C. Lodge Cemetery Washington, DC 4 ☐ Donetion 5 ☐ Other (Specify) 21, Signature Funerel Service Licensee 22. Name end Address of Facility Stein Hebrew Memorial F. H. 232 Carroll St. NW Washington, DC 20012 Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tailure. List only one cause on each line. interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) CEREBRO VASCULAR ACCIDENT WEEKS Examiner Due to (or as e consequence of): Examiner that the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or as a consequence of): USB BS Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PARKINSONS DISEASE Division of Vital Records. à 8 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Mursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours a Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. To the Within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alivar, M.D. D 36552 NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 MONTROSE ROCKVILLE ROAD 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature Registrar

of the Later and

State of Maryland / Department of Health and Mental Hygiene

November 6, 1999

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey 1999 Month **Physician** 4:25 AM November Sidney Bryan Knott /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth.
Months Days Hours Min. (Month, Dey, Yeer)
February 15, 1917 6. Sex 10 M 2 F 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpleca (Stete or Foreign Country) **Funeral** Yrs. 82 Maryland 217-36-6776 **Director** Usuel Residence of Decedent with the Maryland 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f shot treumstic event, the Medical Examines, must be notified at 1 Yes No Directo Maryland St. Mary's Chaptico 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 24440 Hurry Road 20621 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heelth and Mentel Hygiena. Important: If item 27 is marked other than "naturel", or items 23a any Injury or other treumatic event, the Medical Examine, market. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca · American Indien. 11. Meritel Stetus 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farm 7th Farmer 18. Mother's Nama (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Mary Ella Nelson James Woodley Knott 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 24440 Hurry Road, Chaptico, Maryland 20621 Mary B. Knott/Spouse altimore, 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 11/8/99 Chaptico, Maryland Christ Episcopal Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nempe end Address of Fecility
Mattingley-Gardiner Funeral Home, P.A. 21. Signeture of Funerel Servica Licenses 23a. Pert1. Enter the disease, of complications that caused the death. So not antar the mode of dying, such as cardiac or respiratory errest, ehock, or heart feiture. I st only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximete Intervel Between Onset end Death Physician /Medical Immediete Ceuse (Finel diseese or condition resulting in death) Examiner Examiner tal allieros derotie sician end burial-transit requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Diseese or injury thet initieted events resulting in daath) Last Due to (or es e consequence of): orfun P.O. Box 68760 attending physician for use as the buria Physician/Medicai Due to (or es e consequence of): 88 441 fruitricy signed by the a d be dateched f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown weenator & Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed peen page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: director 25. Wes case raferred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Deeth funeral 28d. Dascriba how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation eftar deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Pleca of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide 24 hours e Funeral C Hospital 29a. Certifier (Check only one) edicai 🔁 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, data end plece, end dua to tha causa(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred et tha time, data and place, and due to the causa(s) end menner statad. 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of cartifier 29c. License number

Registrar

31. Dete filed (Month, Day, Year)

NOV 0 9 1999

John Fenwick, MD

32. Registrer's Signatura

30. Neme en address of person who completed cause of deeth (itam 23a) (Type, Print)

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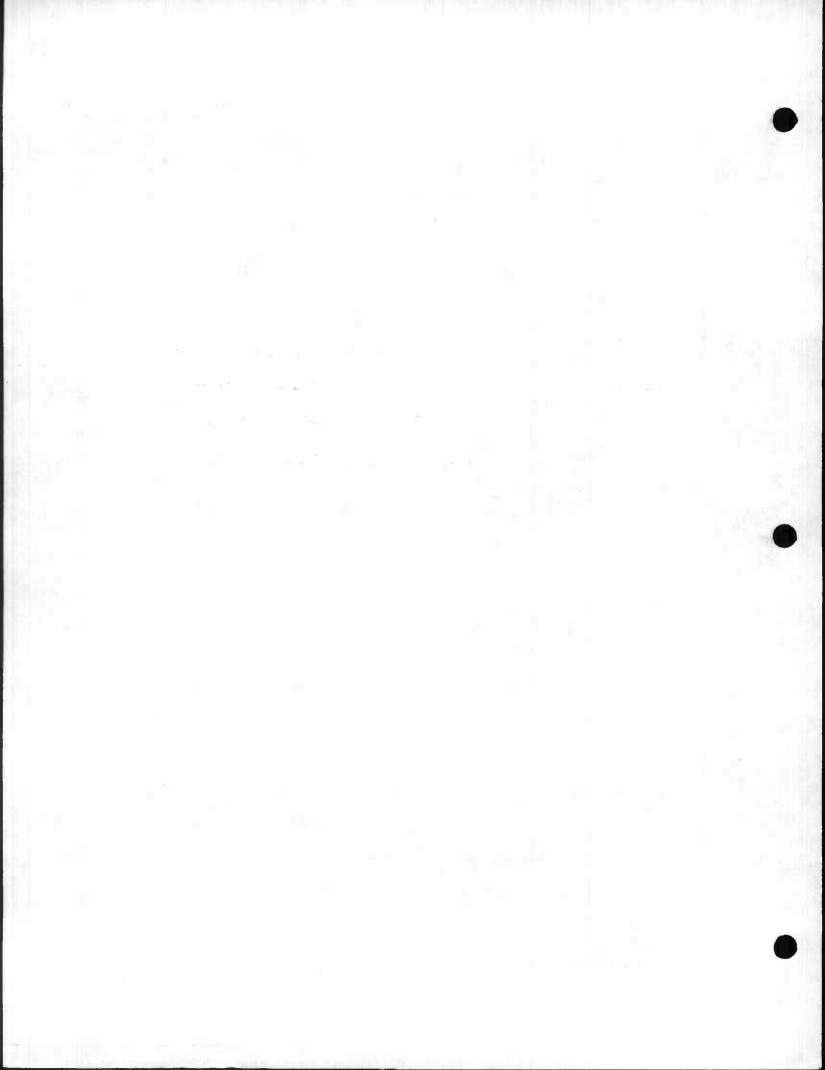
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Leonardtown, Maryland 20650

Marin and Summer of Summer

State of Maryland / Department of Health and Mental Hygiene 99 37931

			Certificate of Deal			Reg. No.	3/331
			1. Decedent's Nama (First, Middla, Last)		2. Data of Dec	ath	3. Time of Death
	Physicia		Marvin Reed KERSHNER		Nov.	Day Y	11:30 p.m.
	/Medica Examine			, Town, or Loc	cation of Death		
	LAMITING	1	17325 Da Wrong Lane	carcto	m	Washing	rton
	Funeral		5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 1 Yaar 1 If U	gerstov nder 24 Hrs.	8. Date of Birt (Month, Da		Birthplace (State or Foreign Country)
	Director		213-40-3208 1∑ M 2□ F 59 Yrs. Months Days Hour	urs Min.	Aug. 1		Maryland
	D Bu	-	10a. Stete 10b. County 10c. City, Town or Location				10d. Inside City Limits
	r 28a-f show	to	Maryland Washington Hagerstown				1 ☐ Yes ②☐ No
	1 the	* -	10a. Sfreef and Number 10f. Zip Code			10g. Citizen of Wha	af Country?
			17325 Da Wrong Lane 21740			U.S.A.	
	er death w Nerre 23e ner munt b	Funeral	11. Meritel Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic	Origin? (Spe	cify Yes or No		American Indien,
Maryland 21215-0020		by Fu	Armed Forces? 1 Never Merried 2 Merried 1 Yes, specify Cuban, Mexi 1 Yes, Sive 1 Yes, Give 1 Yes, Sive 1 Yes, Sive 1 Yes, Specify Cuban, Mexi 1 Yes, Speci		sican, etc.)	Specify:	White, etc. White
2	2 ho	P	15. Decedent's Education 16a. Decedent's Usual Occupation			16b. Kind of Busin	ness/Industry
21	Ban J	Completed	(Specify only highest grade completed) (Give kind of work done during material life. DO NOT use retired) (Give kind of work done during material life. DO NOT use retired)	most of workin	ig .		
5	Hygien Hygien ther the	00	12 4 Manufacturing Eng	gineer		Truck Ma	nufacturer
밀		Be	17. Father's Neme (First, Middle, Last)	lother's Name	(First, Middle,	Maiden Sumame)	
yla		0	Irvin McKinley Kershner Gle	endine	Margue	rite Ree	ed
lar	4 a a a		19e. Informent's Neme/Relettonship (Type, Print) 19b. Meiling Address (Street and Nur	imber or Rura	Route Numbe	er, City or Town, Ste	ete, Zip Code)
	and saith m 27 her tr	L		Beverl	ly Ma.		
ore	Pages 1 nent of H nnt: If liter ary or off	2	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete		Date	20c. Location - Cit	ty or Town, Stete
Ē	C 18 19 1		4 Donetion 5 Other (Specify) Greenlawn Memorial P.				
Baltimore,	Depart Depart Import any Inj ance		21. Signeture of Funeral Service Loanses 22. Name end Address of Fa 415 E. Wilso	11-1		uneral Ho erstown,	
			23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	h es cardiac o	respiretory ar	rest,	Approximete
	Physician		SHOOK, OF HEART IMMURE. LIST ONLY ONE COURSE OF SOUTHING.				Intervel Between Onset end Deeth
4	/Medical		Immediate Ceuse (Finel disease or condition Hypertensive cardio				10 years
	Examiner		rasulting in deeth) Due to (or es e consequence of):				
٠	D # .		Vascular Disease				
	ifficate be executed g physician and as the burial-transit	edical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying				
68760,	be ey	E .	Cause (Disease or injury				
387	phys the	200	thet initieted events resulting in deeth) Lest Due to (or es a consequence of):				
	- 0 6		d				
Box	death cer e attendir ed for use	100					
P.0.	that the death cert ed by the attendin detached for use	Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pe	ert I.			bute to the cause of death?
	± 00	2	Diabetes Mellitus Type 2		10	Yas 2∑No 3	Probably 4 Unknown
ds	requires neen sign hould be	D D			24a. Wes	an eutopsy	24b. Were autopsy findings
Vital Records,	v require been si should	Completed	Hyperlipemia			med?	available prior to completion of cause of death?
Re	hysician: The law nis certificate has b I director, page 2 s	E			101	res 2 🗓 No	1 ☐ Yes 2 ☐ No
tal	ification. T		25. Wes case referred to medical 26 PI	Place of Death	(Check only o		10195 20190
>	Physician: this certific ral director,	To Be	examiner? Hospital: Other			lence 6 Other	(Snecity)
o	Phys arthis eral di		27. Manner of Death 28e. Dete of Injury 28b. Time of 28c. Injury ef			now injury occurred	
0	Attending or death.	atio	1 ☑Neturel 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2	2 🗆 No			
Division	Atte ecto by th	2	3 ☐ Suicida 4 ☐ Homicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)	2	8f. Location (S City or Tox		or Rural Route Number,
Ö	s afte	Certification:	building, ac. (Specify)		ony or vo	, σιατογ	
			29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date 2□ Medical Examiner: On the basis of axamination end/or investigation, in my opinion, one of menner steled.				
	vithin vithin compl		29b. Signature and title of certifier 29c. License number	ber		29d. Date signed (Month, Day, Year)
	. , , , ,		DO-1062		1	November	20, 1999
		3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
			Edward W. Ditto, III 217 W. Washington Street	Hage	rstown	Md. 217	40
	State	е 3	31 Dete filed (Month Day Year) 32 Beniftrar's Signature				
	Registra	r	NOV 2 2 1999				



Director

Funeral

ð

Completed

3. Time of Death NOVEMBER 12, 1999 6:05AM

4e. Fecility Name (If not institution, give street end number) St. Mary's Hospital

4b. City, Town, or Location of Deeth

Leonardtown

4c. County of Deeth

Funeral Director

th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show trammatic event, the Medical Examinar must be notified at

Peges 1 and 2 should be filed within 72 hours efter death vent of Health and Mental Hygiene.

Int: If Hean 27 Is marked other than "natural; or iteme 23s mir. If Hean or other traumatic event, the Medical Essaning man

Baltimore, Maryland 21215-0020

the Menyland

10h County

If Undar 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) Deys

8. Dete of Birth (Month, Dey, Year) May 7, 1933

St. Mary's Birthpleca (Stete or Foreign Country) Maine

027-26-3175 Usuel Residence of Decedent

5. Sociel Security Number

10a State

Maryland St. Mary's

10c. City, Town or Location Mechanicsville

Yrs

10d. fnside City Limits 1 ☐ Yes 2 ■ No

10e. Street and Number

66

10f. Zip Code 20659

10g. Citizen of Whet Country? United States

28410 Charles Street

12. Wes Decedent Ever in U,S. Armed Forces?

13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yes 2 ■ No Specify:

14. Raca - Amarican Indien, Bleck, Whita, atc. Specify: White

1 Never Merried 2 Married 3 ■ Widowed 4 □ Divorced

1 ☐ Yas 2 ■ No If Yes, Give Yeer or Detes: 15. Decedent's Education (Specify only highest grede completed)

Kohut

1□M 2■F

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementery/Secondery (0-12)

Coilege (1-4or 5+)

Home Health Aide

Health Care

17. Fether's Neme (First, Middle, Last)

Milton Axel Peterson

18. Mother's Name (First, Middle, Maiden Sumeme)

Helen Ingrid Ek 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

19e. Informent's Name/Reletionship (Type, Print)

28410 Charles St., Mechanicsville, MD 20659

Nancy L. Griffin, Daughter 20a. Method of Disposition

1 ☐ Burial 2 ■ Cremation 3 ☐ Removel from State

20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece)
Metropolitan Crematory

Dete 20c. Location - City or Town, Stete

4 ☐ Donetion 5 ☐ Other (Specify)

11-13-99 Alexandria, Virginia

21. Signatur of your strong Orbos

Blankenship, M0857

23e. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

22. Nama and Address of Facility Brinsfield Funeral Home P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279

Physician /Medical Examiner

physician s the buriel

USB

signed by the etter

page 2

funeral director.

certificate

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific

To the Hospital or Atterwithin 24 hours efter dea To the Funeral Director completely filled in by the

Box 68760,

P.O.

Records,

of Vital

Division

KATHLEEN KOHUT

permit. Pege Depertment of Important: If any Injury or

Immediete Ceuse (Finel diseese or condition resulting in death) Examiner sician end buriel-transit

Physician/Medical

þ

Completed

Certification: To

Medical

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest

Due to (or es e consequenca of)

Due to (or es e consequance of):

Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 26. Plece of Deeth (Check only one)

of death?

Approximate Intervei Betwaen Onsat and Death

25. Wes case referred to medical examiner? 1 Yes 20 No 27. Menner of Deeth

5 Pending investigation

6 Could not be determined

spital: 1 Inpetient 2 ER/Outpatient 3 DOA

28e. Date of Injury
(Month, Dey Yeer)

28b. Time of Injury
Injury

28c. Injury

28e. Piece of fnjury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

29a. Certifier

1 Neturel

3 Suicida

2 Accident

4 Homicide

1) Confliging Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Exeminer: On the dasis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29b. Signature and title of or

29c. License number

29d. Date signed (Month, Dey, Year)

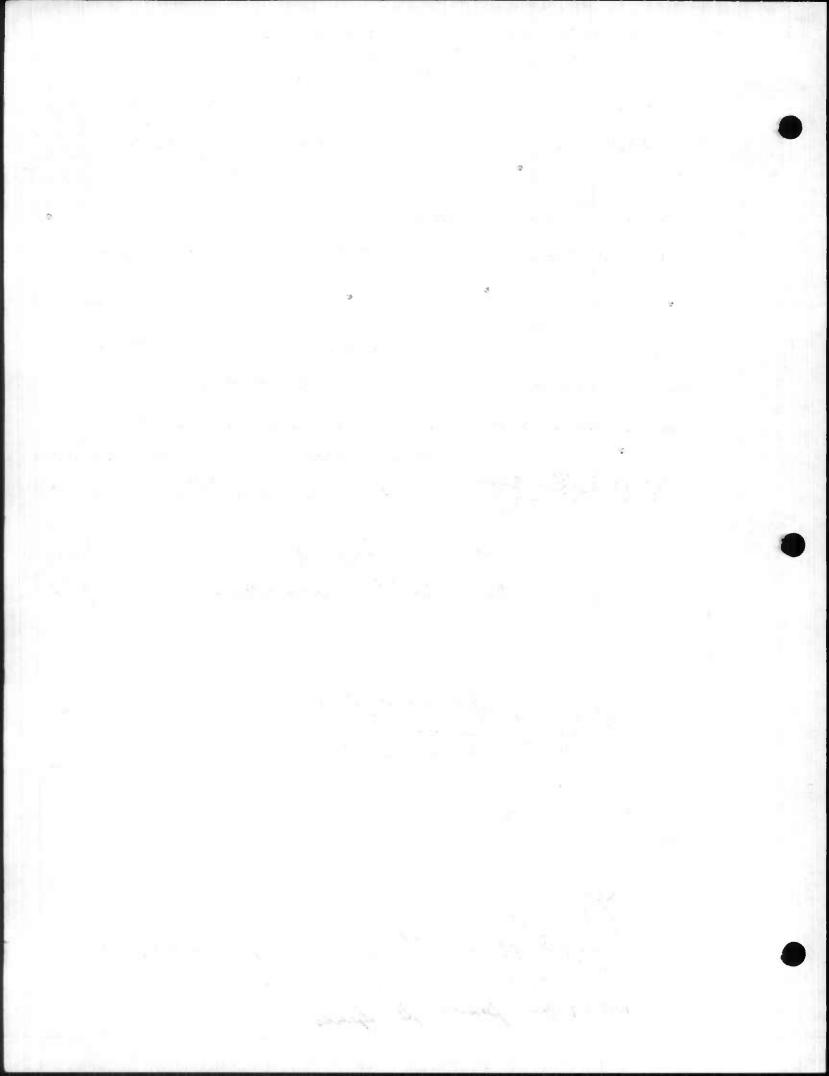
28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

30. Name end eddress

rson who completed cause of deeth (Item 23a) (Type, Pri DR JAMES **JARBOE**

HOLLYWOOD, MD. 20636

State Registrar 31. Dete filed (May) 32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 37933

11/20/99

				Centificate (or Death	1	Reg. No.	0 1 2 0 0	
Physician	1. Decedent's Name (First, Middle,					2. Date of Dea Month	Day	3. Time of Death Year	
/Medical	WILDA IRENE	KILDOW			I	Novembe			
Examiner	4s Facility Name (If not institution, 1107 OAKLAND	The latest transfer of the latest transfer of)		MT. LAKE	PARK	GAI	RRETT	
Funeral Director	5. Social Security Number 220–26–9758	4CM ACE	ge (In yrs. last birt	hday) If Under 1 Y Months Di	ear If Under 24 Hrs ays Hours Min.		y. Year) 1930	Birthplace (State or Foreign Country) MARYLAND	
2	Usual Residence of Decedent 10a. State 10b. County		10c City Town	or Location				10d. Inside City Limits	
deen win the maryend me 23e or 28e-f show met be notified neral Director		10b. County 10c. City, Town or Location GARRETT MT. LAKE PARK							
or 28e-fe be notified Director	10e. Street and Number		1	10f. Zip Co	de		10g. Citizen of	What Country?	
0 A O	1107 OAKLAND AV	107 OAKLAND AVENUE			n		USA		
ar, or items raminar m by Funer	11. Marital Status 1 Never Married 2X Marrie 3 Widowed 4 Divorced	12. Was Decedent	Armed Forces? 1 ☐ Yes 2 Ñ No		21550 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rication of the Yes 2⊠ No Specify:			ce - American Indien, ck, White, etc.	
"natural", idea En	15. Decedent's (Specify only highest	Education	16a.	Decedent's Usual O	ccupation	dring	16b. Kind of B	usiness/Industry	
the M	Elementary/Secondary (0-12)	College (1-4or	5+) L	ide. DO NOT use re EGAL SECR	one during most of wo stired) ETARY	Na y	LAW OFFICE		
o other event, Be Co	17. Father's Name (First, Middle, Li	est)			18. Mother's Na	me (First, Middle,	Maiden Sumen	meme)	
merked medic e	JAMES EDWARD	TASKER			RUTH	OHNSON			
it of Heelth er if Nem 27 le or other treu	19a. Informant's Name/Relationshi	p (Type, Print)	19b.	Mailing Address (St	reet and Number or R	ural Route Numbe	er, City or Town,	State, Zip Code)	
	MICHAEL KILDOW - HUSBAND P.O. BOX 2212 MT. LAKE PARK, MD 2155							550	
	1 N Buriel 2 Cometion 2 Decreased from State cornetery, crematory or other place)							NTD MADVIAND	
	-, -, -, -, -, -, -, -, -, -, -, -, -, -								
Departmen Important: eny injury pnce.	21. Signatural of Funeral Service Li	1	M00167	DURST FI	UNERAL HOM		BOX 24 AND, MD		
ysician Medical raminer	shock, or heart tailure. List or Immediate Cause (Final disease or condition resulting in death)	a. Rena.	l Carci		Sarcoma			Intervel Between Onset end Death	
ale CE	T	Live:	r metas					1 month	
viriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a c	onsequence of):					
ding physicien end	that initiated events resulting in death) Last	d	Due to (or as a co	onsequence of):					
or u	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld							ntribute to the cause of death?	
igned by the be deteched if by Physic						172	Yes 2 No	3 Probably 4 Unknown	
2 should							en eutopsy med?	24b. Were eutopsy findings aveilable prior to completion of cause of death?	
page Com						101	res 200 No	1 ☐ Yes 2 ☐ No	
rector, par Be Co	25. Was case referred to medical examiner?					eth (Check only o	ne)		
5 G	1 ☐ Yes 2 ☐ Yelo	Hospital: 1 ☐ Inpati	ent 2 ER/Out			lome 5 Resid	dence 6 □Ott	ner (Specify)	
the funeral cation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga				Injury at Work? 1 Yes 2 No	28d. Describe t	now injury occur	Ted	
200	3 Suicide 6 Could no 4 Homicide determin	ad 266. Place of in	jury - At home, far ic. <i>(Specify)</i>	m, street, factory, of	lice	28f. Location (S City or Tox		ber or Rural Route Number,	
Funer stely fill dical	29a. Certifier (Check only one) 17 Certifying 2 Medical Ex	Physician: To the best taminer: On the basis of and manner st	f examination and	death occurred at the	ne time, date end place my opinion, death occ	e, end due to the curred at the time,	cause(s) and m date and place,	anner as stated. and due to the cause(s)	
M omple	29b. Signature and title of contine	, /		29c. Lie	cense number		29d. Date signe	d (Month, Day, Year)	

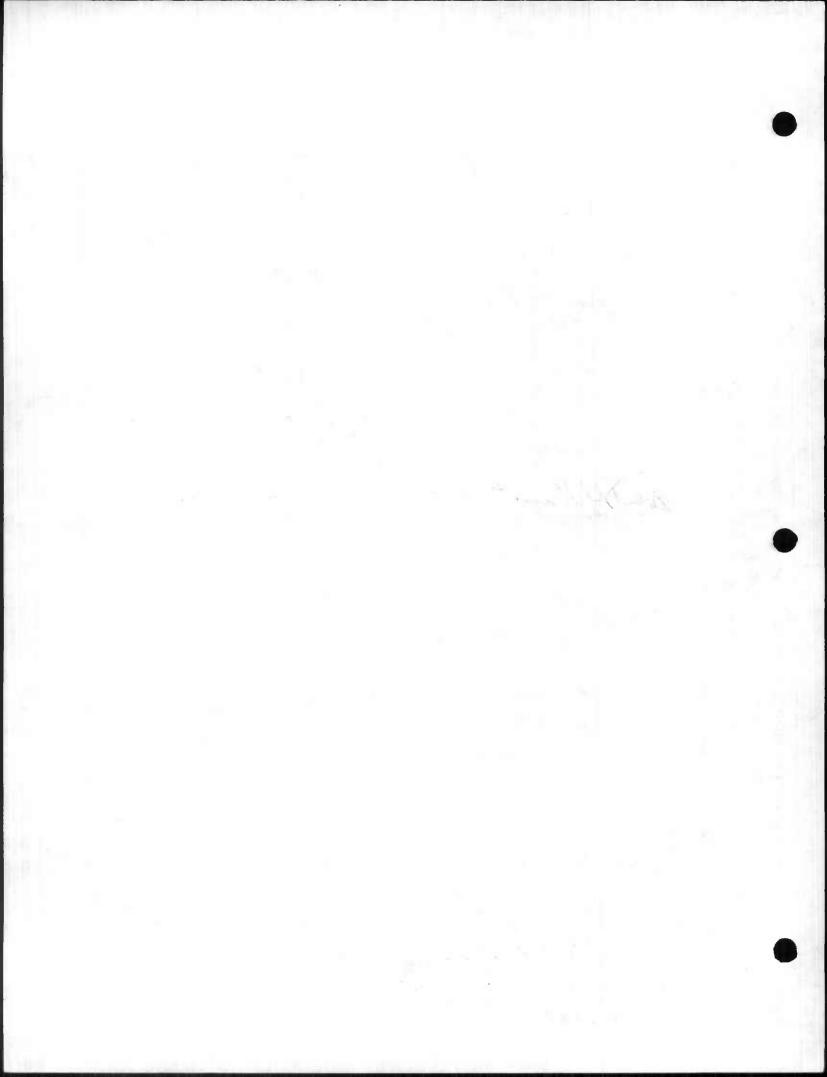
State Registrar 31. Date filed (Month, Day, Year) NOV 2 2 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karl E. Schwalm 32. Registrar's Signature

311 N. 4th St., Oakland, MD 21550

D27205

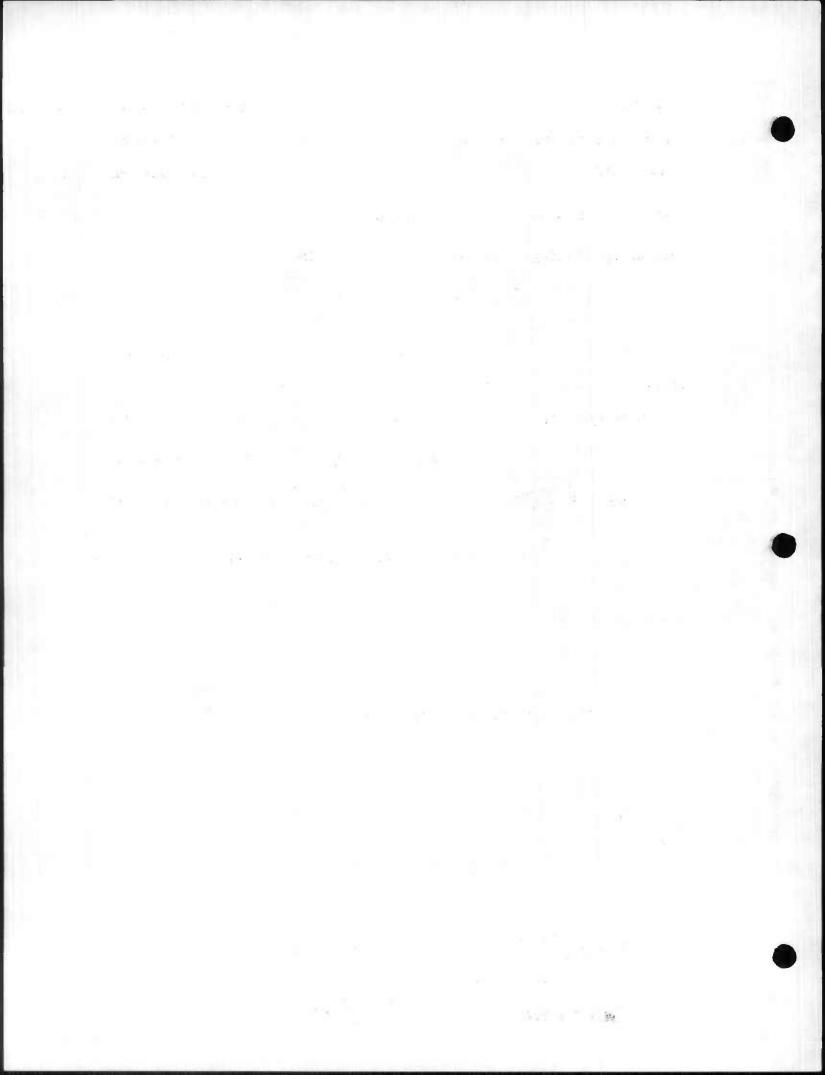


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 3 7 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Dey Yee **Physician** Charles A. Kyle 18, Nov. 1999 11:45P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, giva street and number) Examiner Cuppett & Weeks Nursing Home Oakland Garrett If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Min. 15 M 2□ F Months Days Hours Director 215-16-4357 75 10, 1924 Maryland Usuel Residenca of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Garrett Oakland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8722 George Washington Highway 21550 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yas, Give WW I Yaar or Detas: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien. Bleck, White, etc. 1 □ Never Merried 2 □ Merried WW II 1 ☐ Yes 2 No Specify: White by 3 ☑ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 11th Mechanic Coal Mining 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnema) Charles Kyle Stewart 19b. Meiling Address (Street and Numbar or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Joseph Kyle/Brother 19210 S. Railroad St., Barton, MD 21521 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State Omega Crematory 11/19/99 Morgantown, WV 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funerel Servica Licensee Stewart Funeral Home 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel e Squamous Cell Carcinoma of Lung diseese or condition resulting in deeth) 2 Months Examiner Due to (or es e consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): g Box 68760 physician Physician/Medical 2 Due to (or as e consequenca of): 987 23b. Did tobacco use contributa to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 2 1√ Yes 2□ No signed by 3 Probably 4 Unknown Chronic Obstructive Lung Disease à 2 24b. Were autopsy findings available prior to Completed 24e. Wes en autopsy performed? completion of causa of deeth? 188 **pege** 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Attending Physician: 25. Wes case referred to medical Be 26. Plece of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Pig. 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: Allar 1 Naturel 2 Accident Injury 5 Pending 1 ☐ Yas 2 ☐ No investigetion or Attend after death Director: Could not be determined 3 Sulcida 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Streat and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours a Hospital Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the 1 within 2 To the 1 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature a D0033464 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Robert M. Coughlin, M.D. Box 8, Eglon, WV PO 26716 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Repealed Registrar



Amended #25, cs 11/18/99, Garrett Co. per Allegany Co. ME

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

7. Age (In yrs. last birthday)

ate	of	Maryland /	Department	of	Health	and	Mental	Hygien
			Certificate	0	f Death	h		Reg N

	. Decedent's Nama (First, Middle, Last)
Physician /Medical	ARDELL T. KLIPSTEIN
Examiner	Fscility Nama (If not institution, give street and number
	MEMORIAL HOSPITAL

5. Social Security Number

2. Data of Death Month Day NOVEMBER 10

4b. City, Town, or Location of Death

CUMBERLAND

18:45

Year

1999

4c. County of Death

ALLEGANY

Funeral Director

d other than "natural", or items 23a or 28a-f ahow avent, the Medical Examinar must be notified at netural I Hyglene.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Saitimore, Maryland 21215-0020 Department of Health and Mental Important: If Itam 27 is marked or any injury or other traumatic ava

> **Physician** /Medical Examiner

use es the burial-transit The lew requires that the death certificate be assecuted pue P.O. Box 68760, the attending physician hed for use es the bura signed by the a of Vital Records. phode peed this certificate has page 2 funeral director, To the Hospital or Attanding Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funaral Division

218-16-4977

KLIPSTEIN

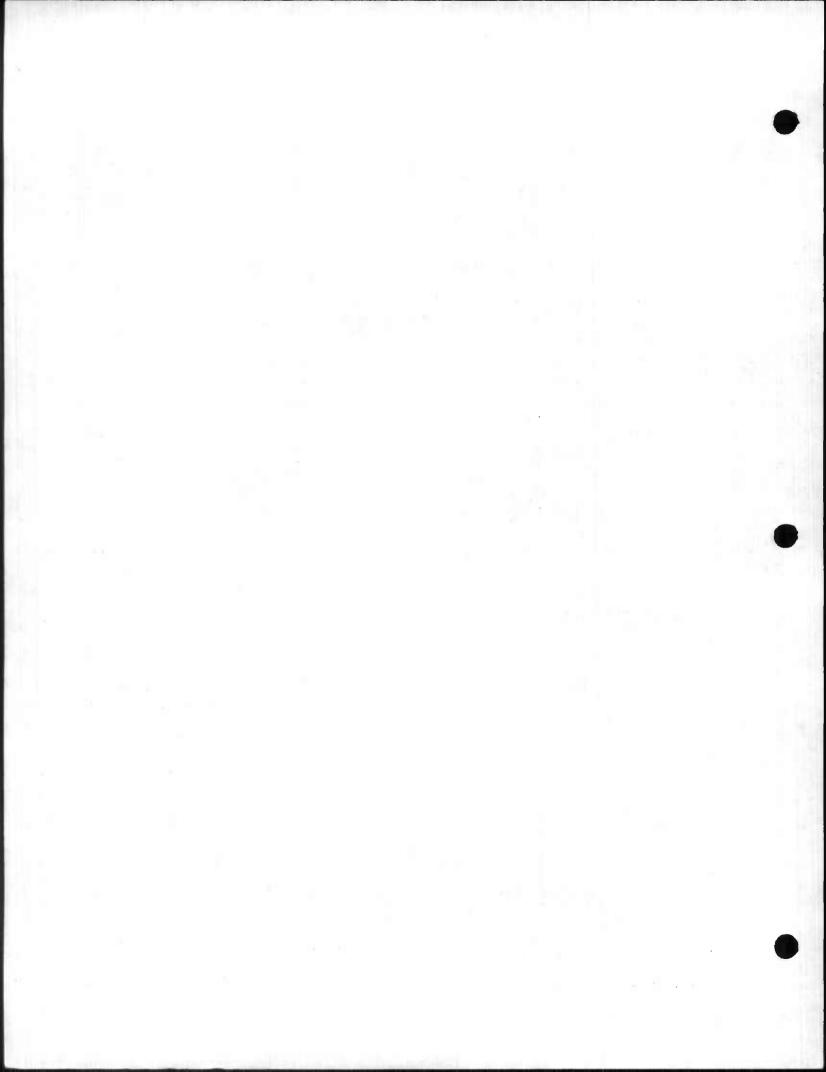
ARDELL

If Under 1 Yaer | If Under 24 Hrs. Months | Days | Hours | Min. 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Months 1 M 2 KD F Yrs. 218-16-4977 76 MARCH 22,1923 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 X No Director MARYLAND ALLEGANY RAWLINGS 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? 21557 P.O. BOX 132 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Datas: 1 Never Msmied 2 Married 1 Yas 2 No Specify Specify: þ WHITE 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 12 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 8 FOSTER G. FRIEND EDITH HONE 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 132, RAWLINGS, LINDA PHILLIPS/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) NOV 15,199920c. Location - City or Town, Stata 20a Mathod of Disposition 1 Denial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) ROCKY GAP VETERANS CEMETERY FLINTSTONE, 2 Signature of Funaral Service Licenses 22. Name end Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY 00 1302 NATIONAL HWY, LAVALE, 21502 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory strest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onsat and Death Immediate Causa (Final diseasa or condition resulting in death) . ASPIRATION 10 MINUTES Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARDIAC DISEASE by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was en eutopsy performed? Completed FRACTURED LEFT HIP 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? release Be 26. Placa of Death (Check only one) axaminer released Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Medicai Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1. Netural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier (Check only one) 🖾 Certifying Physician: To tha best of my knowledge, death occurred et the time, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, deta and place, and due to the causa(s) and manner stated. 29b. Signeture and talle of certifier 29c. License number 29d. Data signed (Month, Day, Year) NOVEMBER'S, 1999 D 48127 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) GREGG WOLFF, JOHNSON HEIGHTS MEDICAL BUILDING, 625 KENT AVE., CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrer's Signatura State

DHMH 16 Rev 6/95

Registrar

NOV 17



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Patricia Ann Lucas 2400 November 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death of Baltimore 5. Sociel Security Number 6. Se Sinai Citz trusve If Under 24 Hrs. If Linder 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Deys Hours 1 M 2 KF 577-70-9886 47 17, 1952 Washington, Oct. Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4601 Pall Mall Rd. USA 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, Bleck, White, etc. ☐ Yes 2☐No Yes, Give 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Detes Black. 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Nurses Aide Private Families 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) James Alston Eliza Lee 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Alston/Sister 12038 Beltsville Dr. Calverton, MD. 20705 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 11-19-99 Washington, D.C. Glenwood Cemetery 4 Donetion 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signeture of Funeral Service Licensee 4308 Suitland Rd. Suitland, MD 20746 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was en autopsy performed? completion of cause of death? 201 No 1 Yes 2 NO No 1 Tyes 25. Was case referred to medical 26. Place of Deeth (Check only ona) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA

The law requires that the death certificate be executed Box 68760, P.O. been signed by t should be detact Records, **page 2** certificata Division of Vital this

Examiner Physician/Medical Be Completed by Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

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Pages 1 and 2 should be ill ment of Health and Mental H ant: if them 27 is marked oth kery or other traumatic even

Department of Important: If any Injury or

Physician

/Medical Examiner

Tree

Noun as

21215-0020

Baltimore, Maryland

Attending Physician: funeral director, After death. within 24 hours after death To the Funeral Director: completely filled in by the ò Hospital

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David 31. Dete filed (Month, Day, Year) State NOV 1 8 1999 Registrar

27. Menner of Death

1 Neturel

2 Accident

4 Homicide

(Check only one)

3 Suicide

29e. Certifier

edicai

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29b. Signeture and title of certifie 30. Name and eddress of parson who completed cause of death (Item 23a) (Type, Print) UY-Dinak

5 Pending Investigation

6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

32 Registrer's Signeture

28c. Injury at Work?

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

1 Yes 2 No

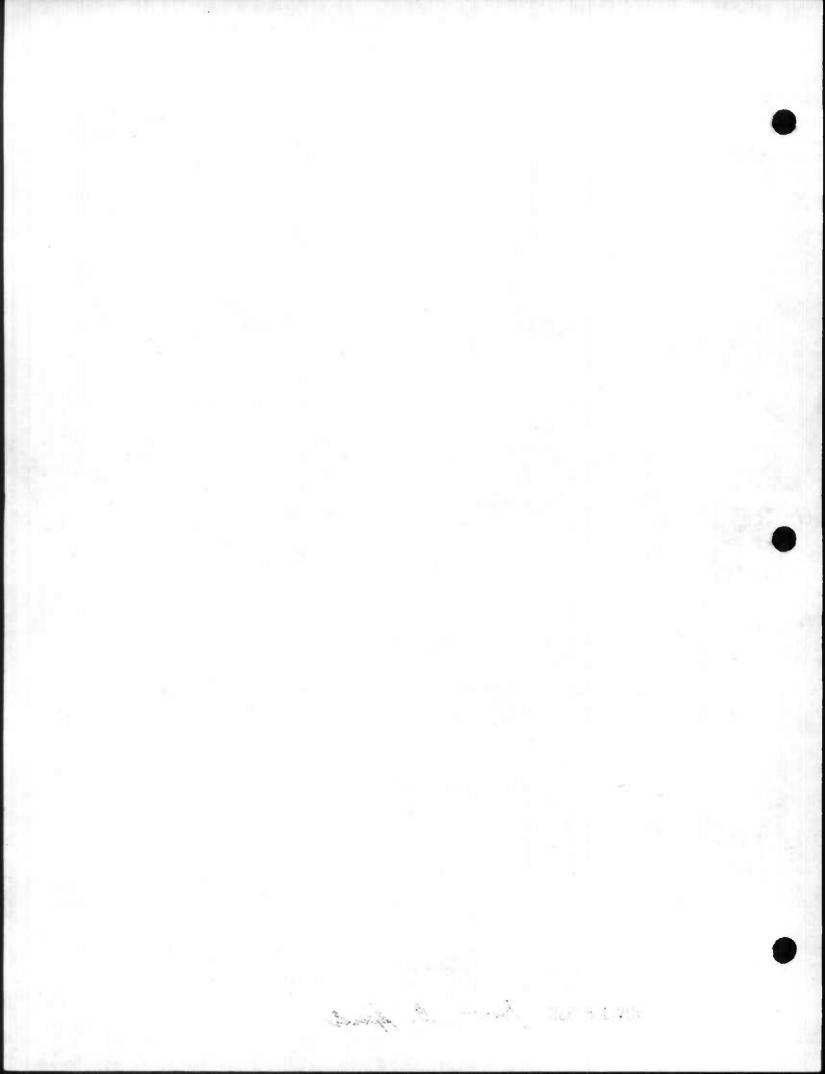
28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

28h Time of

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth Day

Physician	
/Medical	-
Examiner	4

Funeral Director

the Marylend 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the lead call Examiner must be notified with filed within 72 hours efter death v Hygiene. ther than "natural", or Items 23

Maryland 21215-0020 12 should be fill h and Mentel H is marked oth permit. Pages 1 end 2 sh Department of Health and Important: If Item 27 ia m any injury or other traum p0058.

Physician /Medical Examiner

buriel-transit requires that the deeth certificate be executed pue ettending physician for use es the burie Division of Vital Records, P.O. Box 68760 98 ed by the e signed by t peen : The law has certificete Attanding Physician: this funeral Affer efter deeth. filled in by ò 24 hours e Hospital pletely

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Completed

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Certification:

edicai To the To the I

State Registrar

3. Tima of Death 1. Decedent's Nama (First, Middla, Last) November 13,1999 14:35PM Philip Y.F. Li
4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 01ney Montgomery General Hospital Montgomery 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiaca (Stata or Foreign Country) 1€M 2□ F Months Days Hours Min. Yrs. 88 China 105-24-3801 May 3, 1911 Usual Rasidance of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2000 Maryland Silver Spring Montgomery Direct 10g. Citizen of What Country? 10e. Streef end Number 10f. Zip Code 14801 Pennfield Circle, Apt#207 20906 Funeral USA 14. Race - American Indian. 12. Was Dacedant Ever in U.S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) Biack, Whita, atc. 1 ☐ Yas 2 █ No If Yas, Give Yaar or Datas: 1 □ Never Merried 2 □ Married 1 ☐ Yas 2X No Specify: þ 3 Nidowed 4 Divorced Asian Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacedent's Education (Spacify only highest grada complated) United States Collega (1-4or 5+) Elementery/Secondery (0-12) 5 Engineer Government 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumerna) Unknown Unknown 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2 2 3 0 6 19e. Informant's Name/Relationship (Type, Print) Edward C. Li/Son 4327 Rolling Stone Way, Alexandria, VA 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20c. Location - City or Town, State Falls Church, 20a. Mathod of Disposition Nov. 1 ₺ Buriai 2 □ Cramation 3 □ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) 20,1999 Virginia Dakwood Cemetery 21. Signature of Funarai Service Licensaa 22. Name and Addrass of Facility Pearson Funeral Home Mal 472 N. Washington St., Falls Church, VA 23a. Part1. Inter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediete Causa (Final disaasa or condition resulting in death) 206717 2 0A45 Dua to (or as a consequanca of): Examiner myocardial Inforc DAYS Sequentially list conditions, if any, laading to immediata ceusa. Enter Underlying Causa (Diseasa or Injury that initieted avants rasulting in death) Last Dua to (or as a consaquance of): metastatic Brunch Physician/Medical Dua to (or as a consequence of):

24b. Ware eutopsy findings evaluable prior to 24a. Was an autopsy performed? complation of ceuse of deeth? 1 Yas 2 PINO 1 Yas 2 No 25. Wes case referred to medical axaminar? 26. Placa of Death (Check only one) Hospital: 1 Dinpatiant 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1□ Yes 2□ No 27. Mannar of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 5 Pending investigation 1 PNeturai 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be data mined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida

29a. Certifier 1 🖰 Cartifying Phyalcian: To tha best of my knowledga, daeth occurred at the time, data and place, and due to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29c. Licanse number 29d. Data signed (Month, Day, Yaar) 29b. Signatura and titia of certifian

m 5 line

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November 14, 1999

23b. Did tobacco usa contributa to the cause of death?

1 Yee 2 No 3 Probably 4 Unknown

30. Name and addless of person who complated ceusa of death (Itam 23a) (Type, Print)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Wheaton ind 11501 Georgie ma

Weiner 31. Date filed Montr Registrar's Signatura 1 7 1999

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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day Vear **Physician** Virginia Elizabeth Lindsay November 13, 1999 11:40 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's Crescent Cities Center Riverdale If Under 1 Year | If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Min 1□M 2X F Months Deys Hours 87 Yrs. Virginia 29, Aug. 1912 Director 225-24-7352 Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a Slete 10b. County 10c. City. Town or Location 7 is marked other than "natural", or itema 23a or 28a-f abov traumatic event, tra Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Prince George's Hvattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20781 U.S.A. 5204 42nd Avenue death v Funeral 14. Race - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Bleck, White, etc. Peges 1 end 2 should be filled within 72 hours after cent of Heelth and Mental hygiene.
Int: if item 27 le marked other than "natural", or iter
INY or other traumatic event, I'm Medicial Examinativy or other traumatic event, I'm Medicial Examinativy. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: P 3 Widowed 4 N Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hot Shoppe Hostess 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Webb Williams Murray 19b. Malling Addrass (Straet and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informent's Name/Relationship (Type, Print) 5204 42nd Avenue, Hyattsville, Maryland 20781 Patsy D. Cumberland - Daughter Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 N Cremation 3 Ramoval from State permit. Pege Department of Important: If any Injury or once. 11/15/99 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 110 Approximate Interval Between Onset and Deeth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel CUNLEI 204116 disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner physician and the burief-transit Sequentially list conditions, if eny, leading to immediate causa. Entar Undarlying Cause (Disaasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 98 USB signed by the e 23b. Did tobaccerusa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tos 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to 24a. Was en autopsy Completed completion of cause of death? ate hes pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, Be 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Norsing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funerel 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No death. investigation 2 Accidant efter death Director: 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide filled in A 24 hours Funeral F Hospital 12 Curtining Physician: To the best of my knowledga, death occurred at tha tima, data and place, end dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the control of the contr 29a. Certifier To the Hosp within 24 hos To the Fune completely fi edical ar: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

State Registrar 31. Dale Month, Day, Year) NOV 1 6 1999

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29b. Signature and title of

30. Name and address



of daath (Item 23a) (Type, P

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month **Physician** November 10, 1999 10:55PM Lorenzo Llerena /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Takoma Park Washington Adventist Hospital Montgomery If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) If Under 1 Yeer 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** 1**X** M 2□ F Days 265-76-1066 70 Yrs. Months Director August 10,1929 Cuba Usual Residence of Dacadani 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits tem 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examiner man be notified at 1 ☐ Yas 2 ☐ No Maryland Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 11302 Monticello Avenue 20902 U.S.A. Funeral 12. Was Dacedant Evar In U,S. Armad Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 Naver Married 27 Married 1 ♥ Yas 2 No Specify: Cuban þ Specify: Hispanic 3 Widowed 4 Divorced Yaar or Dates: Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 16b. Kind of Businass/Industry 15. Dacedant's Education (Spacify only highast grada complated) pernit. Pages 1 and 2 should be filed within: Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "r any Injury or other traumatic event." Elamentary/Secondary (0-12) Collega (1-4or 5+) Restaurant Owner Restaurant 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be Unknown Lorenzo Llerena 19a. Informent's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) Teresa Lopez Llerena 1629 Columbia Road N.W. #705 Washington, D.C. 20009 20a. Mathod of Disposition
1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 20b. Piaca of Disposition (Nama of 20c. Location - City or Town, Stata camatary, cramatory or other placa) 4 ☐ Donation 5 ☐ Othar (Spacify) 11/16/99 Clinton, Maryland Forest Hills Cemetery 22. Nama end Addrass of Facility 21. Signatura of Funaral Sarvice Licensea W.H. Bacon Funeral Home

3447 14th Street N.W. Washington, D.C. 20010 Bacon 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest shock, or heart feliure. List only one cause on each line. Approximata Intarval Batwean Onset end Deeth

Immadiata Ceuse (Final

ACUTE MYOCARDIAL

Due to (or es e consequence of): CORONARY ARTERY

Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disease or injury that Initiated avants resulting in death) Last

disease or condition rasuiting in daeth)

Dua to (or es e consequence of):

Part II. Othar algni	flcant conditions contributing	to death but not rasulti	ing in tha undarlying caus	sa givan in Part I.
RENAL	FATLURE,	HYPERK	ALEMIA	٠
	STIVE HEAR			
DEComp	PENSATED	COPD	•	

23b.	DId	tobecc	o use	con	tribute	to	the	ceuae	of	deal	lh?
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24b. Ware eutopsy findings aveilable prior to 24e. Was en eutopsy completion of cause of deeth?

1 Yas 2 No 1 TYes 2 No 26. Pleca of Daath (Check only ona)

25. Was casa referred to medical exeminar? Hospital: 1 XInpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation Injury 1 Yas 2 No 6 Could not be 28e. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Certifying Phyeiclen: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and mannar as stated.

| Medical Exeminer: On the basis of axamination and/or invastigation, in my opinion, daath occurred et the time, dete end piece, end due to the cause(s) and manner stated.

29a. Cartifian 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certiling 29c. Licansa number

30. Name and eddress of person who use of deeth (Item 23e) (Type, Print)

PARK DRIVE GREENBELT MD 20770. 6712 VILLAGE YISA. O. YUSSUF MD 32. Registrar's Signetura 31. Data filad (Month, Day, Yeer)

State Registrar

NOV 1 5 1999

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Baltimore, Maryland 21215-0020

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Physiclan /Medical

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To the Within 2

Division of Vital Records, P.O. Box 68760.

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Certification:

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27. Mannar of Daath

1 Natural

2 Accidant 3 Suicida

4 Homicide

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Baitimore, Maryland 21215-0020

To the Hospital or Attanding Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

			Certifica	te of	Death	Re	g. No.	1 3	01940
1. Decedent's Nema (First, Middle	, Last)					2. Data of Deat Month	h Day	Year	3. Time of Death
Marcus Tyrone	Mullen					Novembe			11:37 P.N
4a Fecility Nema (If not institution,	, give street and numb	er)			4b. City, Town, or L		4c. County		
Malcolm Grow Ho	ospital, Ar	ndrews A.	F.B.		Camp Spr		Princ	ce Ge	orge's
, , , , , , , , , , , , , , , , , , , ,	6. Sax 7.	Age (In yrs. last b	Months	Days	If Under 24 Firs. Hours Min.	8. Data of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
577-88-9179		29	Yrs.			Dec. 27	, 1969	Was	h., D.C.
Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City. Ton	vn or Location					1	0d. Inside City Limits
District of Co	lumbia	100. 00, 10.	TO COURTON	W	ashington			- 1	1½ Yes 2□ No
			Time =						
10e. Street and Number		u =	10t. Z	p Code		10	Og. Citizen of V		
3000 - 13th		#5			0020				States
11. Marital Status	12. Wes Decede Armed Force	is?	13. Was Deci	dent of H cify Cubi	fispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - Americ k, Whita,	an Indian, etc.
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3 Widowed 4 Divorced	Yaar or Data								
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12th	ect)		C	lerk		O (Cine Alida A		ivate	
17. Father's Nama (First, Middle, L		Т			15. MOTHER'S NAM	a (First, Middle, A		18)	
William Hatc		-				Bonita M			27107
19a. Informant's Name/Relationsh					and Number or Ru				
William H. Mull	en, Jr				Village (
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation	3 □Removel from Ste	comot	of Disposition (Na ary, crematory or	me of other plac	ce)	Date	20c. Location -	City or To	own, Stata
4 □ Donation 5 □ Other (Sp			ny Memor	ial	Park 1	1/22/99	Land	over,	MD
21. Signifura of Funaral Service L	icensee	_	22. Name a	nd Addre	ss of Facility	Stewart	Funera	1 Hom	10
INV. T	The sail	111	4001	Damm	ing Rd.,				20019
23a. Part1. Enter the disease, or o	complications that cause	sed Tria death Do			-			0. 2	Approximata
shock, of heart failure. List of	only ona causa on aacl	n line.	Trot Gritar grig tric	oo or aya	19, 0001723 0010100	or respiratory arre	,,,		Interval Between Onset and Death
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disaasa or condition resulting in death)	a	Vanu	Dupa	X G	0	est		- 1	
resulting in death)		Dua to (or as a	consequence of	:				1	
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Sequentially list conditions, if any, leading to immediata		Dua to (or as a	consequence of	*					
causa. Entar Underlying Cause (Disease or Injury	6							1	
that initiated events rasulting in daath) Last	<u> </u>	Dua to (or as a	consequence of)			/ I			
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	0							1	
Part II. Other significant condition	ns contributing to death	but not resulting	in the underlying	cause giv	ven in Part t.	23b. Did to	bacco use co	ntribute to	the cause of death?
						1 🗆 Ye	s ANO	3 Pro	bebly 4 Unknown
							71		
						24a. Was a			ere autopsy findings ailable prior to
				_		perform	neu?	CO	mpletion of cause death?
						Note:	•□•	A	/
						Ye		12	Yes 2 No
25. Was case refarred to medical axaminar?	Hospital:	37		Oth		th (Check only on	θ)		
1 Nas 2 No	1 Ll Inpi			UA	4 LI Nursing H	ome 5 Reside			y)
27. Mannar of Death 1 □ Natural 5 □ Pending	1 1 1	Day Year) 28b.	Time of Injury	28c. Injur Wor		28d. Describe no	w sijury occur	CH	1/01
2 Accident invastig	othe fli	199 00	+00 M		Yes 2 No	Jun	100	2/0	whed
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	Physician: To the be xaminer: On the basis								
one) /	and manner		- or miresingello	, army U	princing Golden GCCUI	TOU GE UTO HING, OR	no and place,		o and cardeo(s)
29b. Signature and title of certified	0	1	25	c. Licens	e number	25	9d. Data signe	d (Month,	Day, Year)
MUGUL	pl 111			(D.C.M.E.		Novembe	r 16	1999
30. Name and address of person w	no complated cause	leeth (Item 23a)	(Type Print)						, 1000

State

Registrar

31. Data filed (Month, Day, Year)

NOV 1 9 1999

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MON 2 8 1999

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey 16 **Physician** Month Dorothy A. Minor November 2:30PM /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner H Under 1 Yeer | if Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | Dec. 14, 1916 1836 Metzerott Road, #323 Prince George's 5. Sociei Security Number 6 Sev 9. Birthplece (Stete or Foreign Country) Virginia 7. Age (In yrs. lest birthdey) **Funeral** 1□ M 2□xF Months 577-30-7366 82 Yrs Director Usual Residence of Decedent the Maryland 10a Stete 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 →Yes 2 □ No Director Maryland | Prince George's Adelphi 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 1836 Metzerott Road, #323 20783 238 United States death Funeral Herns . 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Maritel Status filed within 72 hours efter 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yes 2 No Specify: p Specify: Black 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private 17. Father's Neme (First, Middle, Last) mit. Peges 1 and 2 should be filt partition of Health and Mental Hy bortant: If Item 27 is marked oth by injury or other traumatic event 18. Mother's Neme (First, Middle, Maiden Sumame) Be Elias Smith Lillie B. Jackson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy A. Minor - Daughter 1836 Metzerott Rd., #323; Adelphi, MD 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 11/23/99 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Memorial Cem. Suitland, MD 21. Signature of Funerel Service Licenses 22. Neme end Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. inter the disease, or complications that cause in the heart failure. List only one cause on each line the deeth. Do not enter the mode of dylng, such as cerdiac or respiretory errest, Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Metastatic Carcinoma Lung Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed physician and Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): as 980 P.O. 1 signed by the at 5 be detached for Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contribute to the cause of death? 1☑ Yes 2□ No 3□ Probably 4□ Unknown Records. by 24b. Were eutopsy findings eveileble prior to page 2 should Completed 24a. Wes en eutopsy completion of cause of deeth? certificate has 1□ Yes 2□No 1 Yes 2 No Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 NResidence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 After this within 24 hours efter death.
To the Funeral Director: After this completely filled in by the funeral is 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Neturel
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital Medicai 29a. Certifier 1☑ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted.
2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steted. completely (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) G. MINASC MD 30938 November 18, 1999 30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 6196 Oxon Hill Rd., Suite B 520; Oxon Hill, MD Bejjenki S. Chary 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Deeth Month **Physician** 1999 5:50AM Nov. Toni Jean Menchan /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) **Examiner** Prince George's Mitchellville 10607 Parrish Lane 8. Date of Birth (Month, Day, Year) Oct. 16, 1944 If Under 1 Yeer 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 21 F Deys Months Hours Min Mississippi Yrs 55 426-92-3392 Director Usuel Residence of Decedent with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Mazical Examinar must be notified at 1 Yes 2 No Directo Mitchellville Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20721 United States permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a any Injury or other traumatic event, the Medical Examinet mustale. 10607 Parrish Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (ĀNo If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. African 1 Never Married 2 N Merrled Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by American 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educational Administrator Government 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Julia Walker Alfonso Patterson 10 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 10607 Parrish Land, Mitchellville, MD Dillard Menchan - Husband 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 11/20/99 Landover, MD 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Memorial Park 22. Name end Address of Facility 21. Signature of Funerel Service License Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 w Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Caranoma Examiner Due to (or es e consequence of) Examiner attending physician and for use es the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of): P.O. Box,68760. Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2/ No 3 Probably 4 ☐ Unknown 1 Yes Division of Vital Records, ģ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? hes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel exeminer?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA After this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) Certification: or Attending 5 Pending Investigation s efter death. 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital hours 24 hours Certifying Physician: To the bast of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier eted cause of deeth (tem 23e) (Type, Print) CAPITOL 30. Name and address of person who co MIN APITOL ITTS 31. Date filed (Month, Day, Year) NOV 1 8 1999 32 Registrer's Signature Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 1999 7:16 AM Frances M. Manasseri /Medical 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 4a Facility Neme (If not institution, give street and number)
Saint Joseph Medical Examiner Center Towson If Under 1 Year If Under 24 Hrs. Birthplaca (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□ M 2以 F 579-52-1879 83 Director June 9, 1916 Canada Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Howard Columbia Directo 280-6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 4977 Columbia Rd. #203 21044 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2CXMerried Specify: White 8 1 Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 8 Pages 1 and 2 should be nent of Health and Mental 10 Benedetta Varrata Benjamin Loguisto 19e. Informent's Neme/Relettonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) or other tr Alfred S. Manasseri/Husband 4977 Columbia Rd. #203, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Ressurection Cemetery 11/20/1999 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. MD 20745 Approximate Intervet Between Onset and Death **Physician** RESPIRATORY FAILURE MINUTES fmmediate Cause (Finel disease or condition resulting in death) /Medical Examiner RIGHT HEMATOTHORAX 3 DAYS Examiner ician and buriai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) CARDIAC SURGERY WEEKS 3 Physician/Medical the t Due to (or es a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS 080 Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIVERTICULITIS OF SIGMOID COLON þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy parformed? Completed ATRIAL FIBRILLATION page 2 s 1 Yes 25. Was case referred to medicat examiner? Certification: To Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral (28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending investigation Metural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier stehy (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051852 30 Name and address of person who completed cause of death (Nem 23a) (Type, Print)
DAVID BRINKER M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32. Registrer's Signeture 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

The law requires that the death certificate be executed

Box 68760.

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Division of Vital

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Hospital

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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death

RYAN	ODELL	MANCE
ASP		

1. Decedent's Neme (First, Middla, Last)

RYAN ODELLE MANCE

2. Dete of Death 3. Time of Death 12 1^{Yea}99 NOVEMBER D 1740

Physician /Medical Examiner

4a Fecility Neme (If not institution, give street and number) 14323 CHAPEL COVE COURT

4b. City, Town, or Location of Death LAUREL

4c. County of Death PRINCE GEORGES

Funeral Director

28s-f show

the Medical Examiner

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"natural",

Hyglene.

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If item 27 la marked other eny injury or other trassections.

the Maryland

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filed within 72 hours efter

21215-0020

Baltimore, Maryland

Usual Residence of Deceden 10a State 10b County

10c City Town or Location

7. Age (In yrs. last birthday)

21

If Under 24 Hrs. If Under 1 Year Days Hours

 Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) August 22,1978 Washington DO

217-17-5649

Director

Funeral

þ

Completed

Prince George's

1 M 2□ F

Laurel

10d. Inside City Limits

1 Ves 2 □ No

20707

Maryland

5. Social Security Number

10e. Street and Number 14323 Chapel Cove Court 10f. Zip Code 20707

Months

10g. Citizen of Whet Country? U.S.A

1 Never Merried 2 Merried 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

Bleck, White, etc. Specify: Black

14. Rece - American Indien.

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+) (+) 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Department Store

17. Fether's Name (First, Middle, Last)

Frank Hawkins Mance

18. Mother's Neme (First, Middle, Maiden Sumame) Patricia Ann Simon

19e. Informent's Name/Reletionship (Type, Print)

Patricia A. Mance / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14323 Chapel Cove Court Laurel, Maryland

20a. Method of Disposition

1 Deurial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place) Gate of Heaven

20c. Location - City or Town, Stete 11-18-99 Silver Spring, Maryland

21. Signature of Funeral Service Licenses

22. Name end Addrass of Facility Slocum Funeral Service

26. Place of Deeth (Check only one)

1601 Kenilworth Avenue, N.E. Washington, DC 20019 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth

Physician /Medical Examiner

disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last

Physician/Medical

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Certification: To

Medical

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Immediate Cause (Finel

QUILLOT WOUND OF HODO

Due to (or es e consequence of):

Due to (or as a consequence of)

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

1 Yes 2 No

24b. Were autopsy lindings aveilable prior to completion of cause of death? 1 Yes 2□ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Netural

2 ☐ Accident

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I,

2 ER/Outpatient 3 DOA 28b. Time of 17:298

Other: 4 Nursing Homa 5 N Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred SUM JECT WAS SHOT.

111 Penn Street, Baltimore, Maryland 21201

6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

11-12-99

28l. Location (Street end Number or Rural Route Number, City or Town, Stete) 143230HAPER COUFUT PRINCE GEORGES ES

29e. Certifier (Check only one) | Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

2\(\overline{\text{Medical Examiner:}}\) On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner steted.

AW

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) NOVEMBER 13, 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) KORFU W)

MAN MON

22. Registrar's Signatura

Registrar **DHMH 16 Rev 6/95**

Box 68760. o م Records. of Vitai Division

The law requires that the death certificate be executed physician the buria signed by this certificate After Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afty completely filled in by the fun

Strange of the strange

566: 1 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Month Henry Francis Matthews 8:30 a.m. November 14, 1999 4e. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Yeer If Undar 24 Hrs. 7. Age (In yrs. lest birthday) Birthpleca (State or Foreign Country) Days 1⊠M 2□ F Months Houra 049-30-1450 Yrs. 59 June 30,1940 Connecticut Usuel Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Prince George's Langley Park 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 8213 New Hampshire Avenue, Apt. 101 U.S.A. 20783 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Reca - American Indian, Black, White, etc. 11. Marital Stetus 1 X Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Company 12 Press Operator 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Sadie Theresa Mahoney Henry Stephen Matthews 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sadie Theresa Matthews - Mother 83 Lillibridge Avenue, Voluntown, CT 06384 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 11/16/99 Alexandria, VA 21. Signeture of Funeral Service Licansae 22. Name end Addrass of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth · AUTO I MMUNE DEFECIENCY SYNDROME Immediate Ceuse (Final years diseese or condition resulting In deeth) Due to (or es e consequence of):

M Immund defeciency vIRVS Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or es e consaquanca of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Tuber alos?s 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified

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items 23a death

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other treumetic event once.

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Baltimore, Maryland 21215-0020

the Medical Examiner

Director

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Completed

Physician/Medical Examiner þ Completed Be To

ettending physician and for use es the burial-tran 3 signed l page 2 should certificate Hospital or Attending Physical States of the death.
 Funeral Director: After this letely filled in by the funeral di this Medical Certification: To the Hospitai or within 24 hours eft To the Funeral Di completely filled in

The law requires that the death certificate be executed

Box 68760.

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of Vital

Division

thet initieted evants resulting in deeth) Last

1 Yes

completion of cause of death? 1 ☐ Yes 2 No

25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

1 ☐ Yes 2 No 27. Manner of Deeth 1 Neturel 2 Accident 5 Pending Investigation

6 Could not ba determined

28e. Dete of Injury (Month, Day Year) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete)

28d. Describe how Injury occurred

29a. Certifier

3 Suicide

4 Homicide

🔯 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 2 Medical Exeminer: On the basis of exeminetion and/or Investigetion, In my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated.

29b. Signatura and title of cartifier

29c. License number D42403 29d. Data signed (Month, Dey, Year) 11/14/99

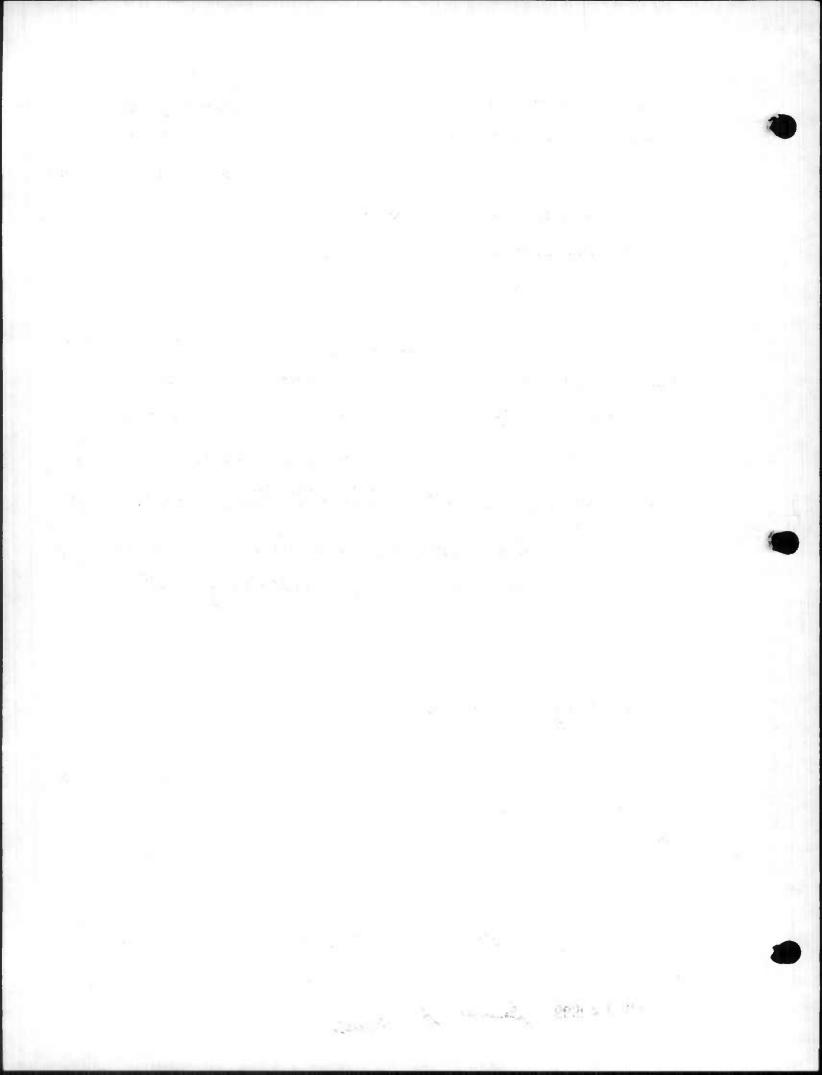
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

106 Irving St. N.W. Wash. D.C. 20012 Signeture KAI MATHUR

31. Dete filed (Morth, Day, Year) NOV 1 8 1999

32. Registrar's Signeture

State Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death November 12,1999 Cleola Beth 9:00 P.M. Myers 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bethesda | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year, | 1921 Suburban Hospital Montgomery If Under 1 Year 9. Birthplace (State or Foreign Country) 1 exas 7. Age (In yrs. last birthday) Months 451-24-1004 1 M 2 DXF 78 Yes Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Prince Georges Hvattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20783 2212 Calvert Street U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐No Specify: Specify: White 3 Widowed ADDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personnel Officer U.S. Government 17 Father's Name /First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Maggie Ann Brumly 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15604 Darwin Court Laurel, MD 20707

Lon Ward 19a. Informant's Name/Relationship (Type, Print) William C. Myers/ Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete NO Burial 2 Cremation 3 Removel from State Ft. Nov. 16, 1999 Brentwood, MD Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Lice 22. Name end Address of Fecility

eilau Ering the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or have feiture. List only one cause on each line.

Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722

DIVERTICULUI Immediate Cause (Finel disease or condition resulting in death)

Approximate Interval Between Onset and Death

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or hams 23s or 28s-f show the Medical Examiner must be notified at

"naturel", or items

flied within 7 Hygiene.

permit. Pages 1 and 2 should be filled v Department of Heelth and Mental Hygie Important: If Nem 27 is marked other?

Physician

/Medical

Examiner

Physician/Medical

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Completed

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Certification:

After this

deeth.

Hospital 24 hours Funeral D

To the Vithin 2 To the F

or All

Baltimore, Maryland 21215-0020

Records,

Funeral

2

Completed

8

Due to (or es a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequence of):

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC NONSMALL

23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown

EAST CANCER

24a. Wes an eutopsy performed?

24b. Were autopsy lindings available prior to completion of cause of death?

1□ Yes 200 No

1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

2 Accident

4 | Homicide

3 ☐ Suicide

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie nduck

6 Could not be

37236

1 Yes 2 No

29d, Date signed (Month, Day, Year)

30. Name and additional of person who completed cause of death (Item 23a) (Type, Print) P. HENDRICKS, M)
Year) 32. Registrar's Signeture CARULYN Do.
31. Date filed (Month, Day, Year)

SUITE 305 6410 ROCKLEDGE DR

26. Piece of Deeth (Check only one)

State Registrar

the way with the

8881 5 1 US 8

Please Type or Print In Black indelible Ink. Assure Ali Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:10 AM CARLOS PEREZ MARISCAL NOV 11 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town. or Location of Death 4c. County of Death Examiner PRINKEGEURGES FORT WASHINGTON FORT WASHING TON HOSPITAL If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Hours Months Days XXM 2 F Yrs. Director 215-51-8292 06-26-44 Huancayo, Peru Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hema 23a or 28a-f ahow the Magical Examiner must be notified at Fort Washington Maryland Prince Georges 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 7700 Webster Lane Peru Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black. White, etc. filed within 72 hours after 1 ☐ Yes 2∰No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 xx Yes 2□ No Specify: Peruvian Specify: Hispanic þ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v. Depertment of Health and Mental Hygie Important: If item 27 is marked other tilenty or other treumatic event, the page. 12 Painter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Carmela Mariscal Aurelia Perez 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlos Perez 13694 Wildflower Lane, Clifton, VA 20124 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Chesapeake Crematory 11 - 13Greenbelt, Maryland 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Sorope Lognyte 22. Name and Address of Facility Strickland Funeral Services, PA 6500 Allentown Rd. Camp Springs, MD 20748 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Duys disease or condition resulting in death) **Examiner** Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Box 68760 415 Physician/Medical 980 P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed be det Records. þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 2 Natural 5 Pending after death.

Director: After in by the fundamental 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) within 24 hours after de To the Funeral Direct completely filled in by I 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 Homicide 5 Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-12-1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPAIGBEOGU, MD 4467 OLD BRANCH AVE. HIOS, TEMPLEHILLS, MO 20748 UCHECHI 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar

395 January 898

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Name (First, Middla,	(act)		Certificate o	f Death	2. Data of De	Reg. No.	3794
nysician Medical	Wilhelmina M					Month Novemb	Day	
miner	4a Facility Nama (If not institution, s Holy Cross			4b. City, Town, or Local Silver			,	
eral tor	5. Social Security Number 577-22-6588	4 CH ACKE	(In yrs. last birthe	Months Day		8. Date of Bir (Month, Da 1/27/	th y, Year) 18	9. Birthplaca (Stata or Country) S. Carolin
V	Usual Rasidance of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. fnside City
ctor	Md. Prince	George's	Upper M	Marlboro				1 X Yas 2
Director	10a. Street and Number 309 Prairie	Ct.		10f. Zip Code 20	772		10g. Citizen of W	
Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces?	ver in U,S.	13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No Rican, etc.)		- Amarican Indian, c, Whita, atc.
	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Datas:	e 1 ☐ Yas 2 ☑ No Specify:			196137	Specify:	Black
1	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+)			supetion ne during most of work red)	king	16b. Kind of Bus	siness/Industry
	17. Father's Name (First, Middle, La Haywood Mil	*		Kitchen Helper 18. Mother's Name (First, Middle, Josephine Bl			Maiden Sumame	
2	19a. Informant's Name/Relationship Leroy Miller, Jr.	*						Stata, Zip Code)
20a. Method of	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3		cemetery,	isposition (Name of crematory or other p	20c. Location - City or Town, State Suitland, Md.			
	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice	**	Lineo	22. Nama and Add H.S.Was	lress of Facility hington &	.5/99 Sons Co	.,Inc.	
_	23a. Part1. Entar tha disease, or co shock, or heart failure. List on	W. Jra	he death Do no	4925 Bur	roughs Ave	., N.E.,	Wash.,D.	C. 20019 Approximata
dical Examiner	Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate	b	ia Dua to (or as a co Dua to (or as a co					
	cause. Enter Underlying Cause (Disasse or Injury that initiated avents resulting in death) Last	c	ua to (or as a cor	nsequence of):				
Ö	Part II. Other significant conditions				given in Part I.		/	tribute to the cause of
y Physician/Me								
	Pancytopenia/M			come		,,,		
2	Pancytopenia/M		Jan Dyria.	rome		24a. Was	an autopsy ormed?	24b. Were autopsy fin available prior to completion of car of death?
ģ	Pancytopenia/M			rome		24a. Was	an autopsy rmed?	available prior to completion of car
o Be Completed by	25. Was case rafarred to medical examiner?	Hospital			26. Place of Dea	24a. Was perio	an autopsy med? Yes 2 10 No	available prior to completion of car of daath?
To Be Completed by	25. Was case rafarred to medical	Hospital: 1 Inpetien 28a. Date of Injury (Month, Day	t 2□ER/Outp	atient 3 DOA	Other: 4 Nursing H	24a. Was perfo	an autopsy rmed?	available prior to completion of cau of death? 1 Yes 2 N
To Be Completed by	25. Was case rafarred to medicel examiner? 1 □ Yes 2 ☑ √10 27. Manner of Death 1 ☑ Natural 5 □ Pending	Hospital: 1 Inpetien 28a. Date of Injury (Month, Day)	t 2□ER/Outp Year) 28b. Tin Inju	atient 3 DOA DOA	Other: 4 Nursing H jury at Jork? Yas 2 No	24a. Was perfo	an autopsy rmed? Yes 2 Ao one) dence 6 Othe how injury occurre	available prior to completion of cau of death? 1 Yes 2 N
Certification: To Be Completed by	25. Was case rafarred to medicel examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not datarmine 29a. Certifier 1 Certifying	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day) tion t be 28a. Place of Injury	t 2 ER/Outp Year) 28b. Tin Inju y - At home, farm (Specify) my knowledga, coxamination and/	atient 3 DOA Cana of 28c. In W M 1	Other: 4 Nursing H jury at lork? Yas 2 No	24a. Was perfect the control of the	an autopsy rmed? Yes 2 ☑ No one) dence 6 □ Othe how injury occurre Street and Number wn, State) cause(s) and mar	available prior to completion of call of death? 1 Yes 2 N or (Specify) and or or Rural Route Numbonner as stated.
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edical Certification: To Be Completed by	25. Was case rafarred to medicel examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not datamine 29a. Certifier (Check only one) 25. Was case rafarred to medicel investigat investigat (Check only 2 Medical Examine)	Hospital: 1 Tinpetien 28a. Date of Injury (Month, Day) 1 be 28a. Place of Injury building, etc. Physician: To tha basis of aminer: On tha basis of and manner state	t 2 ER/Outp Year) 28b. Tin Inju y - At home, farm (Specify) my knowledga, coxamination and/o	atient 3 DOA 28c. In a of 28c. In a of 1 leath occurred at the prinvestigation, in my 29c. Lice	Other: 4 Nursing H jury at Jork? Yas 2 No se time, data and place y opinion, death occu	24a. Was perfect the control of the	an autopsy rmed? Yes 2 100 one) dence 6 00the how injury occurred. Street and Number with, State) cause(s) and mandata and place, a	available prior to completion of call of death? 1 Yes 2 N or (Specify) ed or or Rural Route Numb. nner as stated. Indidua to the cause(s)

01 : 5 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Jack Ernest Month Yee Myers 1999 3:15 AM 19 NOVEMBER a. Facility Neme (If not institution, give street end number) St. Mary's Hospital 4b. City, Town, or Location of Death 4c. County of Deeth Leonardtown St. Mary's 8. Date of Birth (Mooth, Dev. Year) October 2, 1921 If Under 24 Hrs 5. Social Sacurity Number If Under 1 Year 7. Aga (In yrs. lest birthdey) 9. Birthplece (Stete or Foreign Devs Months 259-14-1906 1 M 2 □ F 78 Hours Mississippi Usuel Basidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Leonardtown St. Mary's Maryland 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whel Country? 20650 United States 22680 Cedar Lane Court, #1201 12. Was Decedent Ever in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. 1 Navar Married 2 Married Yes 2 No 1 ☐ Yes 2 ■ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Collage (1-4or 5+) Elamantary/Secondary (0-12) US Government Teacher 17. Fether's Neme /First Middle Last) 18. Mother's Nema (First, Middla, Maidan Surnama) John Maurice Myers Emma Duty

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient importants if itsm 27 is marked other that any injury or other traumatic event, that once. **Physician** /Medical Examiner

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signed by the etta

page 2 certificete has

funeral director,

After this

Completed

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Certification: To

2 Accident

3 ☐ Sulcide

4 Homicide

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 26s-f shortha Medical Examiner must be notified at

I Hygiena.

Director

Funerai

Completed by

Be

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

20e. Mathod of Disposition

William P. Myers, Brother

1 ☐ Burial 2 ■ Cramation 3 ☐ Ramovel from State

Doward N.Brinsfield, Jr., M00052

23a. Pert1. Enter the diseese, or complications that caused the death. shock, or heart failure. List only one ceuse op each line.

filed within 72 hours efter death with the Manylend

21215-0020

Baltimore, Maryland

P.O. Box 68760,

Division of Vital Records.

Physiclan:

or Attending

Examine sician and buriel-trensit The law requires that the death certificeta be axecuted physician s the burie Physician/Medical

(or es e consequence of)

Immedieta Ceusa (Final disaasa or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseesa or Injury that initiated events resulting In death) Lest Part II. Other eignificant conditions contributing to death but not resulting in the undarlying causa givan in Pert I. 23b. Did tobacco use contribute to the cause of death?

19381 Sunset Drive.

Do not enter the mode of dying, such as cardiac or raspiratory agrast,

20b. Plece of Disposition (Name of cematary, crematory or other plece)

Metropolitan Crematory

by 25. Was casa rafarrad to medical exeminer? Hospitel: 1 patient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 1 No 27. Mannar of Death 28b. Tima of 5 Panding invastigation 1 Naturel

1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed?

1 Yas

2 No

20c. Location - City or Town, Steta

Approximate Intervel Between Onset and Deeth

11-20-99 Alexandria, Virginia

26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

Leonardtown, MD

22. Name end Address of Fecility Brinsfield Funeral Home P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279

28e. Deta of Injury (Month, Day Yeer) 28c. Injury et Work? 1 Yas 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, straat, fectory, office building, etc. (Specify)

29a. Certifier া Certifying Physicien: To tha best of my knowledge, daath occurred et the time, date end placa, end due to tha cause(s) end mannar as stated. the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, data and place, and due to the causa(s) in manner stated/ (Check only one)

29b. Signeture end title of

JAMES P. JARBOE M. D 31. Date filed (Morkh/Cour, Year) NOV 2 2 1989

6 Could not be

29d. Data signad (Month, Day, 29c. License number

causa of deeth (Itan 23a) (Type, Print) 30. Name and address of person who com

PHILIP J.BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636

State Registrar

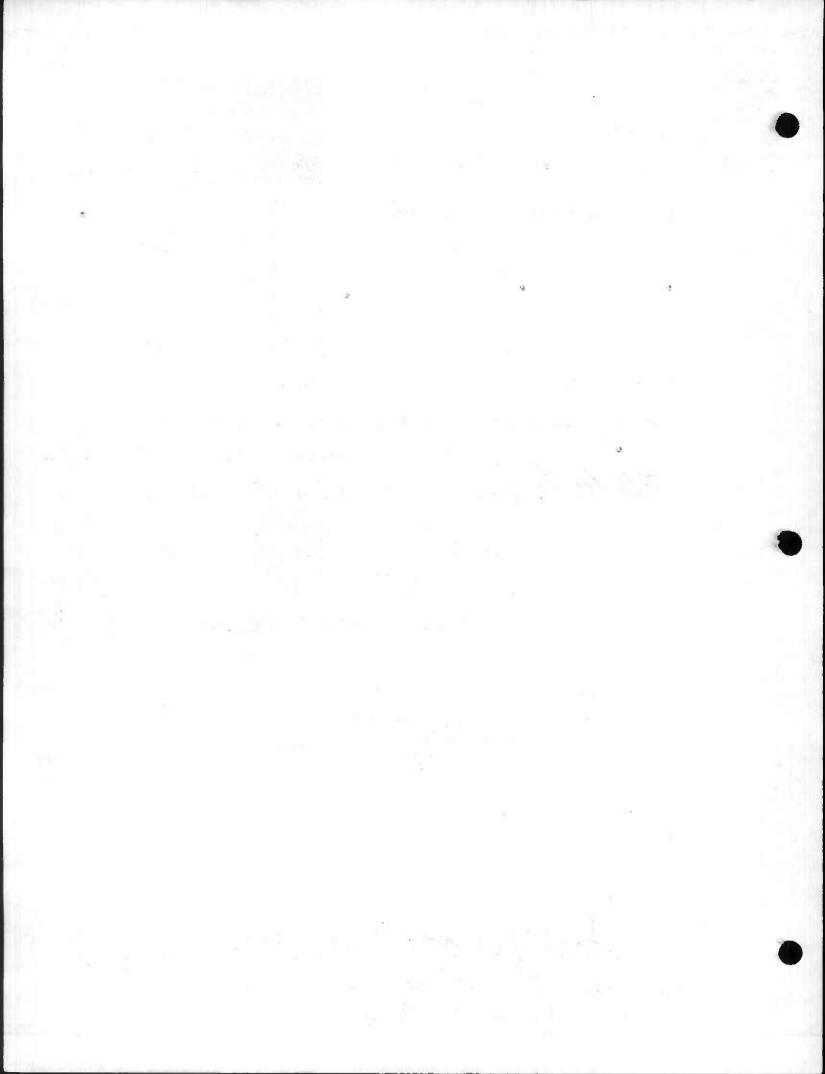
32. Registrer's Signeture

DHMH 16 Rev 6/95

JACK ERNEST MYERS within 24 hours after daath.

To the Funeral Director: A completely filled in by the ft

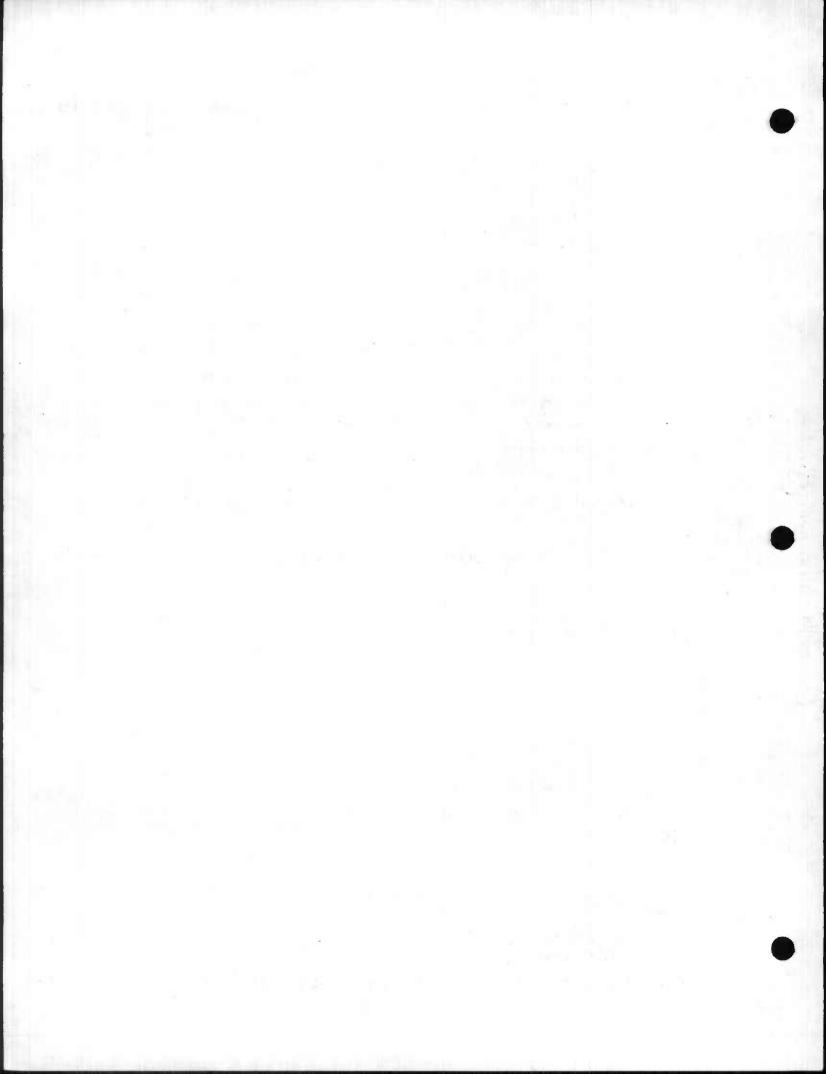
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State of Maryland / Department of Health and Mental Hygiene 99 37950

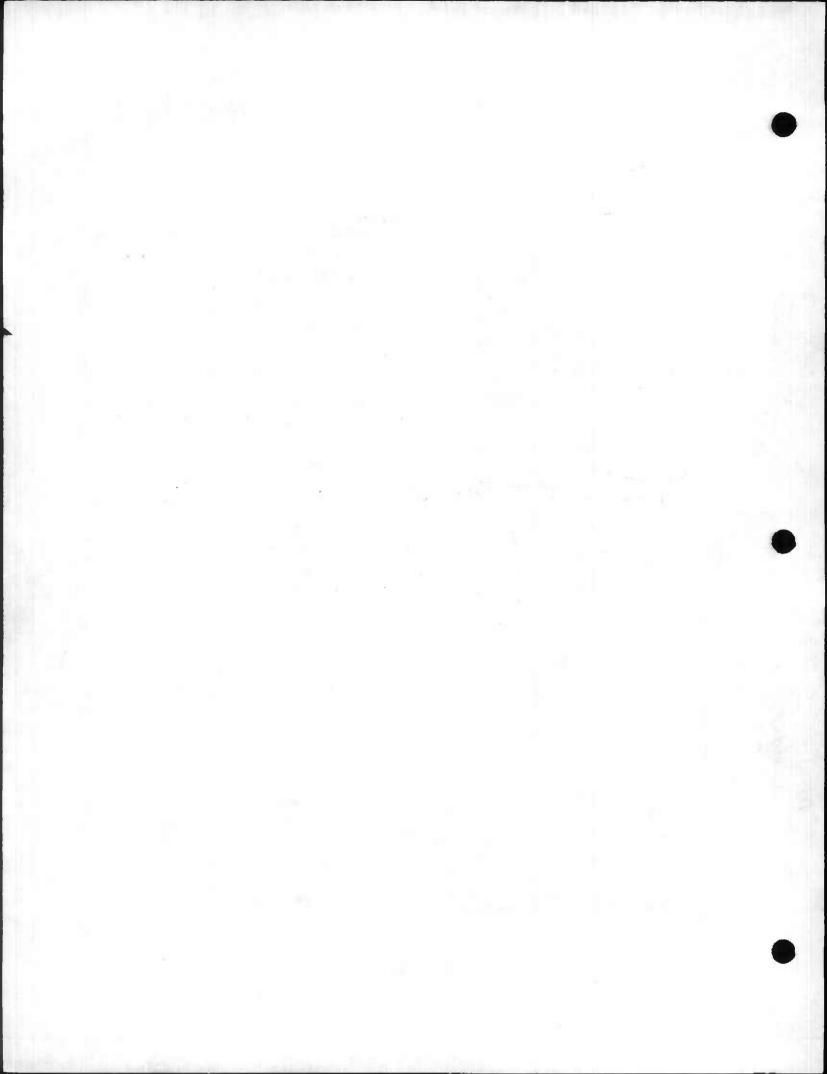
			(Certificate	of Death		Reg. No.	3 3	1930
Physician	Decedent's Nama (First, Middle, L. Georgetta Cather					2. Date of De Month	eath Day	Year 1999	3. Time of Death
/Medical Examiner	4a Facility Name (If not institution, gi Washington Count	ve street and number)			4b. City, Town, or Hagers		h 4c. Count	y of Death	n County
Funeral Director		Sex 10 M 20 F 7. Age (1	n yrs. last birtho	Months I	Year If Under 24 Hrs Days Hours Min	. (Month, Di	#b	9. Birthpl Count	laca (Stata or Foreign
yland	Usual Rasidence of Decedent 10a. State 10b. County	10	Dc. City, Town o	or Location				10	0d. Inside City Limits
vith the Mar or 2844 at be notified		gton Co.	Hagerst				1[
death with the Maryland ms 23e or 28e-f show crinist be notified at ner at Director	10e. Street and Number 14108 Zinnia Lar	ne		10f. Zip C	21742		10g. Citizen of U.S.A		
- 2 2 E	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Datas:	?? If Yes, specify Cuban, Mexican, Po No 1 ☐ Yes 2 ☑ No Specify:			(Specify Yes or No- erto Rican, etc.) 14. Race -/ Black, V Specify:			
15-C	15. Decedent's E (Specify only highest gr	ade completed)	16a. D	ecedent's Usual (Give kind of work of a DO NOT use	Occupation done during most of wo retired)	orking	16b. Kind of B	lusiness/Ind	ustry
I 21215-0 led within 72 ho tygiene. The Medical Completed	Elamantary/Secondary (0-12)	College (1-4or 5+)	College (1-4or 5+)		gement		Departme		Store
Maryland 21215-0020 of 2 should be filled within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Exercitivaments ovent, the Medical Exerci	17. Father's Name (First, Middle, Last Melvin David Rec	, _				me <i>(First, Middle</i> Harriet			
Aary 2 shou is mar reument	19a. Informant's Name/Relationship				Street and Number or R				
re, rend Heelth	S. Dwight Morgar 20a. Melhod of Disposition		20b. Place of D	isposition (Name	ville Road	, Hagers	20c. Location		
Baltimore, semit. Peges 1 er populari (1 lean 2 mportant: If Item 2 mportant: If Item 2 mportant: or other 2008.	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			erematory or other even Cem		Nov.27	Hagers	town,	Maryland
Bali Bali Departiment import	22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland								
Physician	23a. Part1. Enter the disease, or conshock, or heart feilure. List only	pplications that caused the one cause on each line.	e death. Do not	enter the mode of	of dying, such as cardia	c or respiretory a	erscown		Approximate Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· Myocal	ndial e to (or as a con	Infe	sution			4	< lhr
Baltim desth certificate be executed desth certificate be executed desth certificate be executed desth certificate be executed and for use as the burial-transit defor use as the burial-transit and injury contact. Sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	c	e to (or as a con						
P.O. Box at the death ce to the ettendi etteched for use	Part II. Other algnificant conditions of	contributing to death but n	ot resulting in th	ne underlying cau	se given in Part I.	23b. Did	tobacco uas co	ontributs to	the cause of death?
							1 Yes 2 No 3 Probably 4 Unknown		
ecord aw requir ss been s 2 should pleted						24a. Was	en eutopsy omed?	ava	ora autopsy findings aliable prior to mpletion of cause death?
f Vital Rec yalcian: The law is, certificate has b director, page 2 s fo Be Comple	OF Was and of the district					10		10	Yes 2□ No
of Vita Physician this certificated director	25. Was case refarred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpo	atient 3 DOA	Other	hath (Check only Home 5 ☐ Res		her (Specify	()
E Property Co	27. Manper of Death 18. Natural 5 Pending 2. Accident Investigation	28a. Data of Injury (Month, Day Ye	ear) 28b. Tim Inju	ne of 28c	Injury at Work? 1 Yes 2 No	28d. Describe	how injury occu	rred	
Division of the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification;	2 Accident Investigation 3 Suicida 6 Could not be determined	98 Place of Injury	- At home, farm Specify)	, street, factory, o			Street and Num wn, State)	ber or Rural	l Route Number,
he Hospiu in 24 hours he Funers pletely fille	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of m niner: On the basis of ex and manner stated	amination end/o	eath occurred et or investigation, in	the time, date and place my opinion, deeth occ	e, and due to the urred at the time,	cause(s) and m dete and plece,	anner es sta , end due to	ated. the cause(s)
To the within To the comp	29b. Signeture and title of certifier	Bentito	MI)	icense number		29d. Date signe		
	30. Name and address of person who	completed cause of death	(Item 23a) (Ty	pe, Print)	t Dr 1	Dillia	พรงาที	t M	d 21795
State	31. Data filed (Month, Day, Year)	32. Redistrar's	Signature	1. Ann	w/s/		t	,	



State of Maryland / Department of Health and Mental Hygiene 99

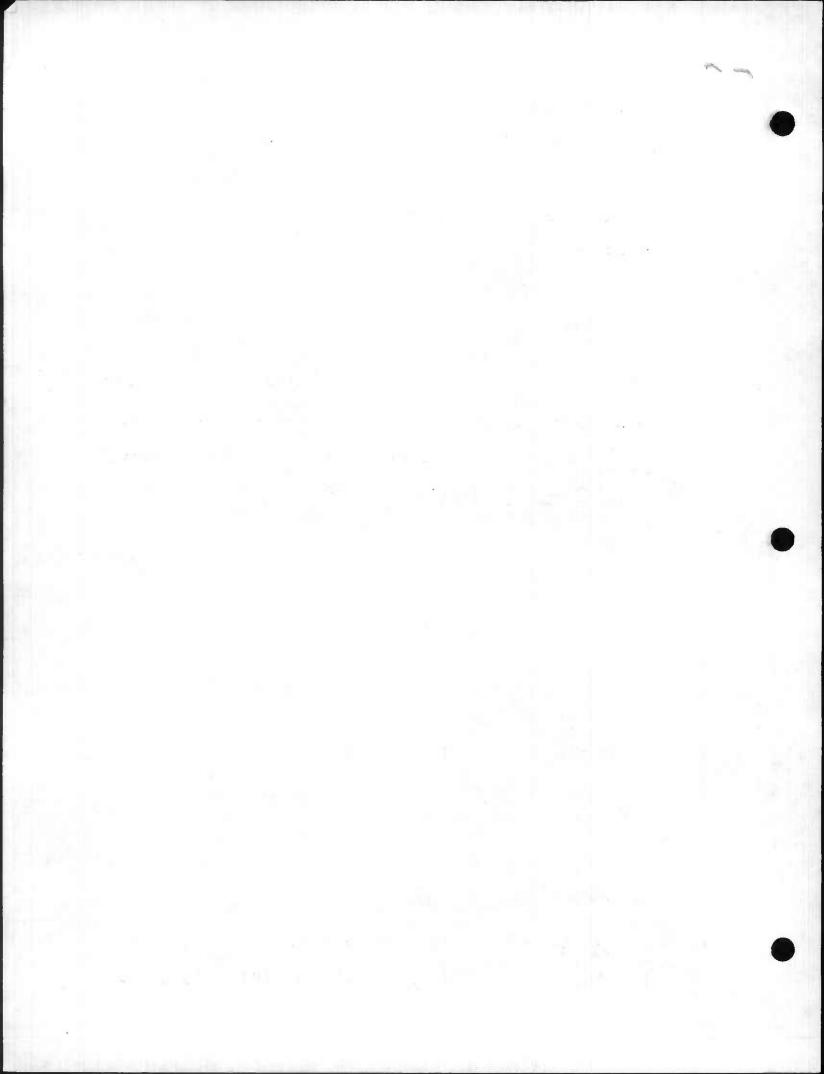
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November Caroline Catherine McAfee 1050 /Medical 4c. County of Deatt 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 6, 1927 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Days 10 M 20 F Months 219-20-3055 72 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Md. Frederick Sabillasville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4621 Foxville Rd. 21780 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filled within 7 Hygiene. pemit. Peges 1 and 2 should be filed within Department of Heelth and Mentel Hygiene. Important: If Item 27 ie marked other then any Injury or other traumatic event. Its Me Elementery/Secondery (0-12) College (1-4or 5+) Factory Seamstress 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Henry Clyde Toms Velma Ruth Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4621 Foxville Rd. Sabillasville, Md. 21780 William R. McAfee (Husband) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 DR Bethel Cemetery Nov. 24, 1999 5 Other (Specty) Foxville, Md. Uneral Service Lice 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physicien and Division of Vital Records, P.O. Box 68760 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physicien: within 24 hours after death.

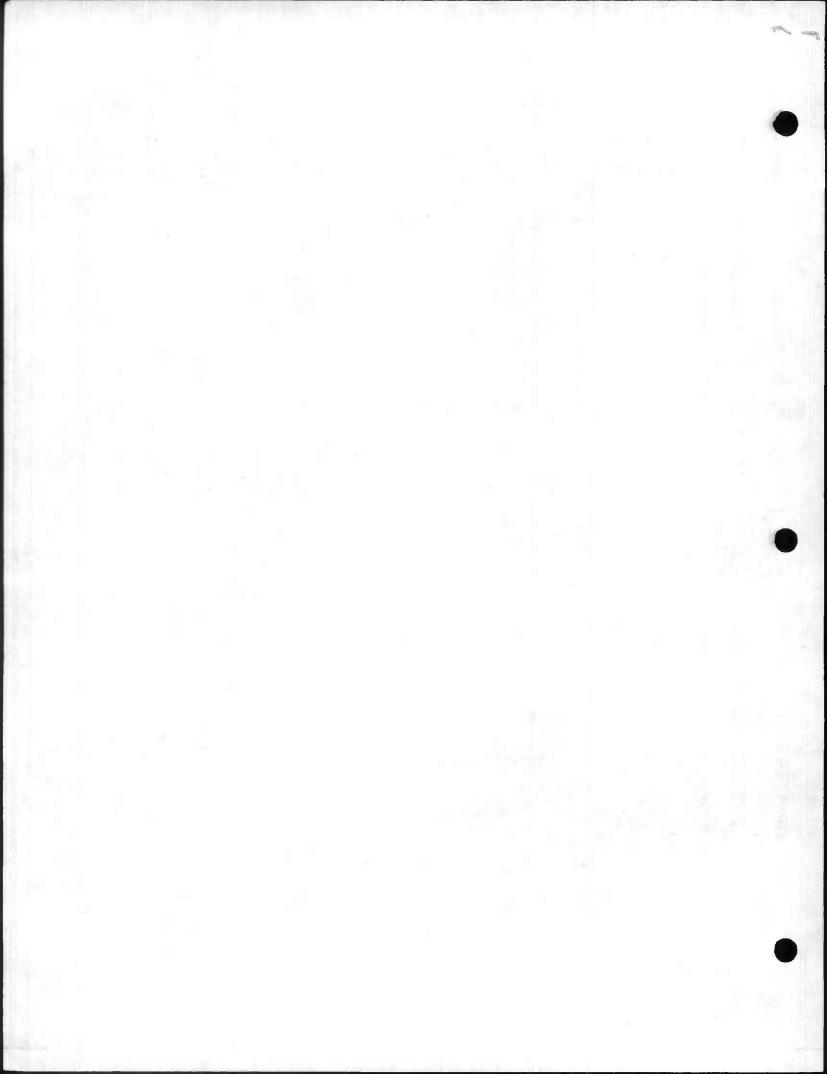
To the Funeral Director: After this certifical completely filled in by the funeral director, 8 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 PER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture shalfitle of county 29c. License number 29d. Date signed (Month, Day, Year) 32. Registrar & Signature State NOV 22 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Yeer **Physician** 0354 NOU Calvin Metger 1997 Emory /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthdey) ff Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** Deys 214-05-4211 15M 20 F Director Jan. 30, 1916 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c, City, Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits Md. 1 ☐ Yes 2 No Director Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21740 15219 National Pike USA death v Funeral 12. Wes Decedent Ever in U.S. Arned Forces?

*Elives 2 NowWII
H Yes, Give
Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, epecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If filem 27 te marked other than "natural"—nary Injury or other traumatic averages. Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White p **3**DWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Toolmaker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Lillie Voghtman Metger Harvey 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Catherine Wesmiller/daughter 15219 National Pike, Hagerstown, Md. 21740 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlel ② Cremetion 3 ☐ Removal from Stete 11/16 Hagerstown Crematory Hagerstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Burner Trade Services 1037 Dual Place Swener MBIF 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or responded, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Final Pneumonia diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementing Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart by 24b. Were sutopsy findings aveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 100 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 10 1 Dinpatient 2 ER/Outpatient 3 DOA ö 曹 28a. Dete of injury (Month, Dey Year) 27. Menurer of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural Attending 5 Pending death. 1 Tyes 2 No Te the Hospital or Atlands within 24 hours after death Te the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20311 Cappains Rd, Bonstono, MD 217/3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malik MD 32. Registrar's Signature State Registrar





DHMH 16 Rev 6/95

altimore, Maryland 21215-0020

The law requires that the death certificate be executed

P.O. Box 68760.

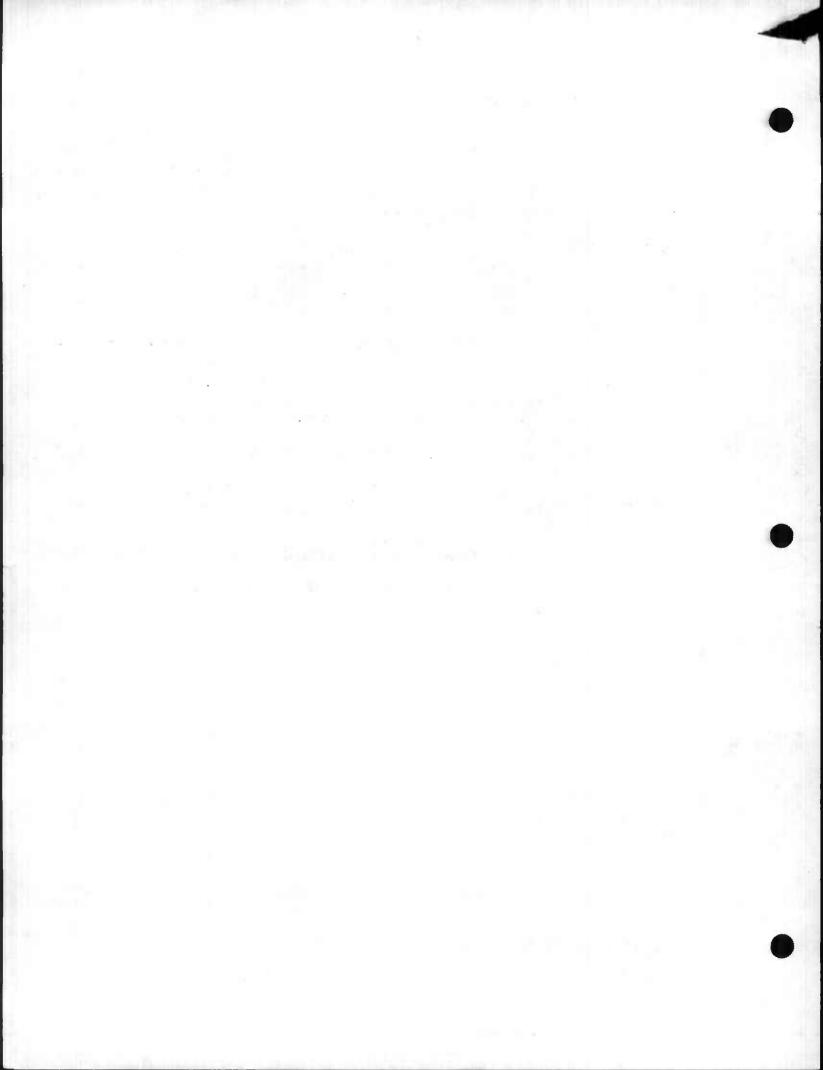
Records.

Division of Vitai or Attending Physician:

Hospital

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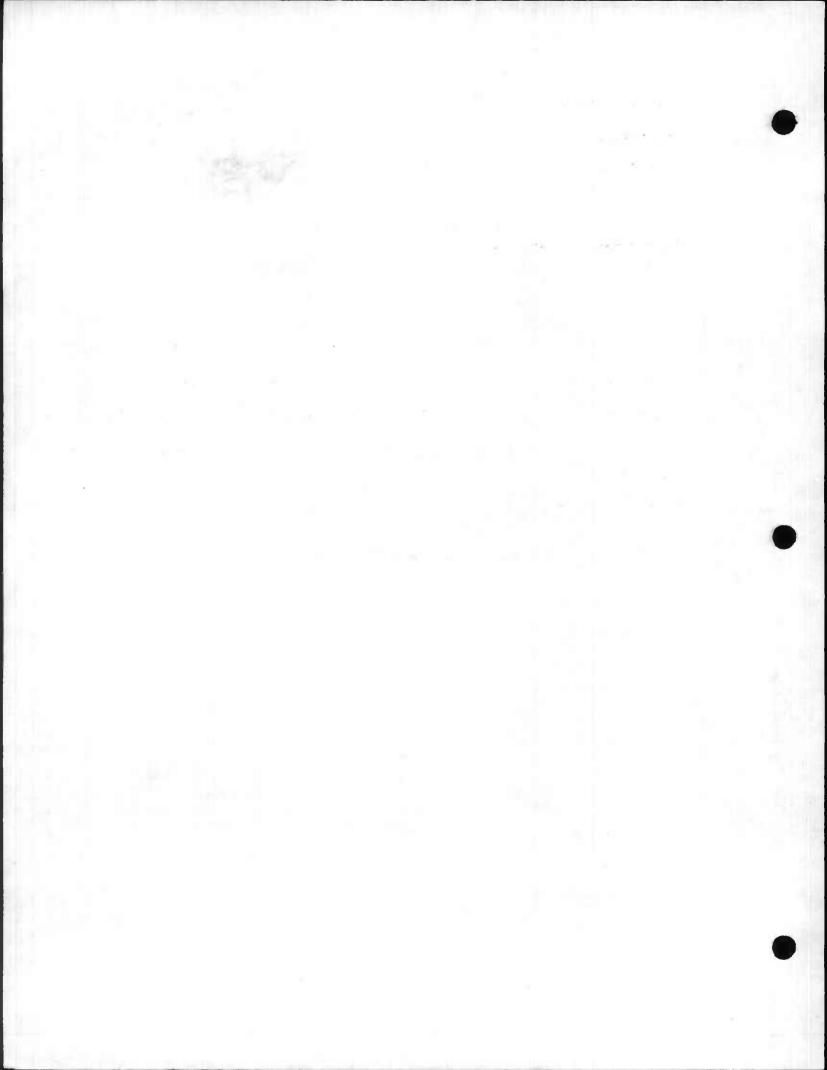


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Kenneth Kneal Mark 4:38 P.M NOV /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington County Hagerstown 8. Date of Birth (Month, Day, Year) June 21, 1938 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10 M 2□ F 173-32-3540 61 Yrs. Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or hems 23s or 28s-f show other traumatic avent, the Medical Examinar must be notified at Maryland Washington Co. 1 Yes 2 No Boonsboro 10g. Citizen of What Country? 10f. Zip Code 늄 7524 Mountain Laurel Road 21713 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 X Yes 2 No If Yes, Give DISCharga: Year or Dates: 1063 1 Never Married 2 X Married altimore. Maryland 21215-0020 White 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced 1963 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cable Television Co. Technician Supervisor 10 0 permit. Pages 1 and 2 should be fitted Department of Health and Mental Hy Important: If Itam 27 is marked other any Injury or other traumatic avanta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Dorothy L. Fidler George Spayd Mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Diane Mark/Wife 7524 Mountain Laurel Rd., Boonsbor, Maryland 21713 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Boonsboro Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov.16 Boonsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd.North, Hagerstown, MD 21742 3a. Part1. Enter the shock, or heart lain. Approximate Interval Between Onset and Deeth and that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Arteriosclerlotic Examiner Due to (or as a consequence of): physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by t 3 Probably 4 Onknown 1 Yes 2 No Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 1 Yes 2 No 1 ∏Yes 2 ∏No certificata of Vitai 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending or Attending To the Hospital or Attandin within 24 hours after death. To the Funeral Director: Af 1 | Yes 2 | No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Fune completely f ner: On the basis of exar and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Hurold RV 0012194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tritch 348 M.D Harold 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1999 NOV 16 Registrar

Kenneth

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MECLUNG

Funeral

Director

must be notified

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Norms 23a

'natural', or

Hygiene.

the Maryla

72 hours after

Important: If Hem 27 is marked other any Injury or other treasured other Pages 1 and 2 should be nent of Health and Mental 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility unnuch **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) schemi Examine Examiner sloian and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medicai Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. vascular disease signed b þ Completed this certificate septal or Attending Physician: hours after death. neral Director: After this certifica 25. Was case referred to medical axaminar? Be 1 Yes 2 No Certification: To 1 Inpatient 22 ER/Outpatient 3 DOA 27. Manner of Death 1 DNatural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Pending 1 Yas 2 No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

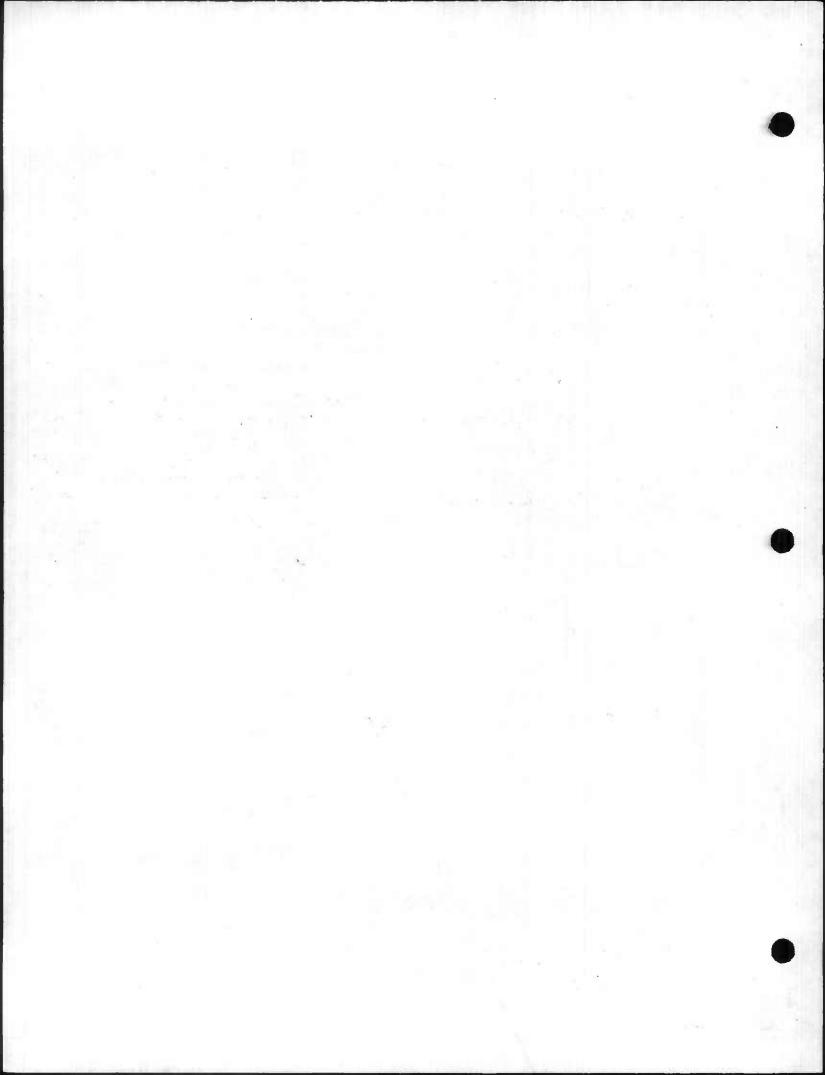
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) SAMUEL J. RAD, MID HWY. MOLLY PITCHER GREEN CASTLE, PA

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death MECLUNG Month **Physician** AVA MARIE 2340 NOVEMBER 12 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON HOSPITAL HIAGERS TOWN COUNTY WASHING-TON If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) Jan. 24, 1942 West Virginia If Under 1 Year Months Days 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1□M 257F 213-42-1527 57 Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Washington Hagerstown YE Yes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 11 West Baltimore Street 21740 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 0-12 College (1-4or 5+) homemaker her own home 18. Mothar's Nama (First, Middla, Maidan Surname) 17. Father's Name (First, Middle, Last) Be Ina Ethel Henson George Edward Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mrs. Elaine Bragunier/sister 11910 Peacock Trail, Hagerstown, Maryland 21742 20c. Location - City or Town, State 16,1999 Hagerstown, Maryland Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 154800 oronary cortery disease 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

13630

State Registrar 31. Date filed (Month, Day, Year) NOV 1 6 1999 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

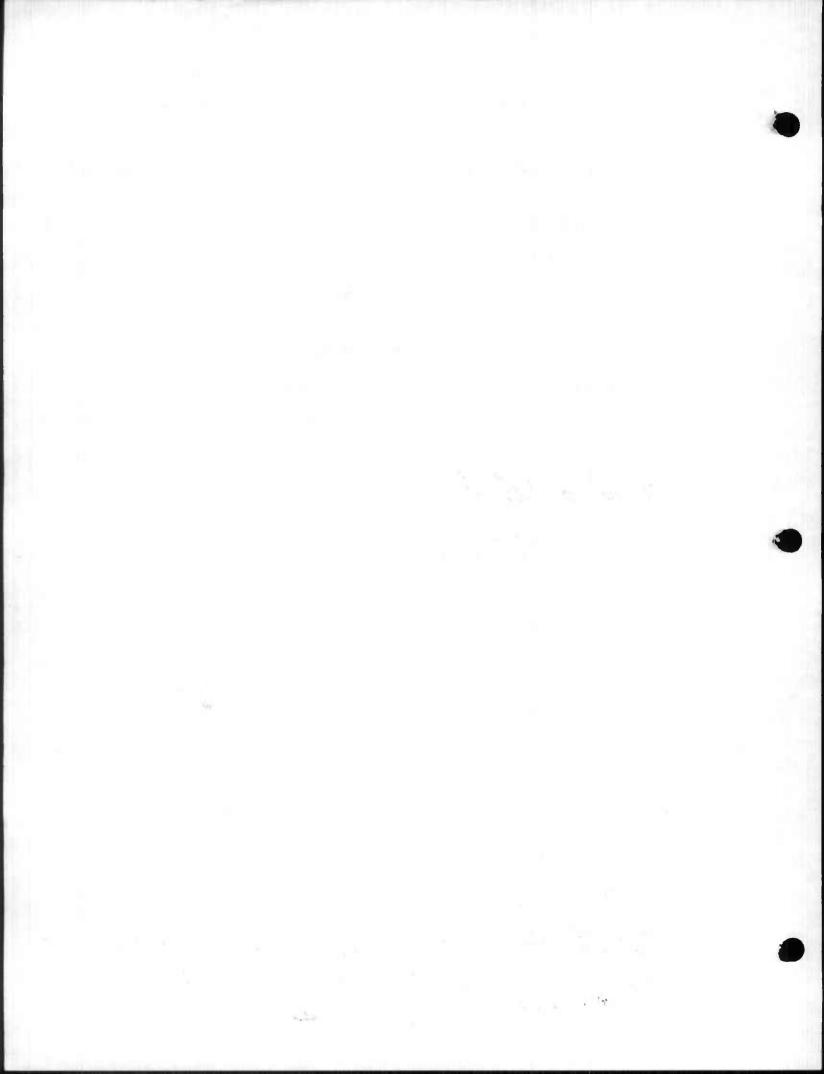
Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Bertha Elizabeth Miller November 17, 1999 09:30 PM /Medical 4e. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daeth Examiner Westernport Allegany 23519 Stoney Run Rd. If Under 1 Year 5. Social Sacurity Number If Under 24 Hrs. 8. Date of Birth (Month, Dey, June 29, 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foraign **Funeral** Months 1□ M **3** F Days 96 Yrs. 1903 215-82-7139 Maryland Director Usual Residence of Dacadant Maryland to or 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Westernport Maryland Allegany the 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with USA items 23a 21562 23519 Stoney Run Rd. death Funerai 12. Was Decadant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Spacify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - Amaricen Indian, ancel Example Black, Whita, atc. filed within 72 hours after 1 □ Navar Married 2 □ Marriad 21215-0020 1 ☐ Yas 2 No Spacify: þ Specify: White 3 ₩idowad 4 Divorcad Completed the Medical 15. Decedent's Education 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT usa retired) (Spacify only highast grada completed) than Elementery/Secondary (0-12) Collage (1-4or 5+) Hygiene. Homemaker Home i. Pages 1 and 2 should be filed with the state of Heelth and Mentel Hygie trant: If Item 27 Is marked other the jury or other traumatic event, to marked other altimore, Maryland 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Fannie Grove Fazenbaker Oliver 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Straat and Numbar or Rural Routa Numbar, City or Town, Steta, Zip Coda) 21517 Brashear Lane, Westernport, MD 21562 Darlene Brashear /Daughter 20b. Placa of Disposition (Neme of camatary, crematory or other placa) 20e. Mathod of Disposition 20c. Locetion - City or Town, Steta 1X Burial 2 ☐ Cramation 3 ☐ Removal from Stata Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Miller Cemetery 11/20/1999 Westernport MD 21. Signature of Funeral Sarvica Licensee 22. Nama and Address of Facility
Boal Funeral Home K a 111 Church St., Westernport, MD 21562 0 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Intarval Batwe Onset and Death Physician Immediate Ceuse (Final disaasa or condition rasulting in death) Dua to (or as a consequence of): Examiner be executed Saquantially list conditions, if eny, leeding to immadiate ceusa. Enter Undarlying Causa (Disease or Injury that initieted avants resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical The law requires that the death certificate the Dua to (or as a consequence of): USB BS atten for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed by Records, by 8 director, page 2 should 24b. Wara autopsy tindings available prior to Completed 24a. Was an eutopsy completion of ceuse of deeth? 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: To setter deeth.

M Director: After this certificat Be 25. Was casa referred to medical 26. Pleca of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2 No funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 ☐ Yas 2 ☐ No 2 Accident Invastigation filled in by the 3 Suicida 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, term, street, factory, offica building, atc. (Specify) 4 Homicide Hospital 24 hours edical 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) mannar stated. completely within 2 9 29b. Signa 29d. Data signed (Month, Day, Year) 29c. Licansa numbar who completed cause of death (Item 23e) (Type, Print) 1999^{2.} Registrar's Signatura State

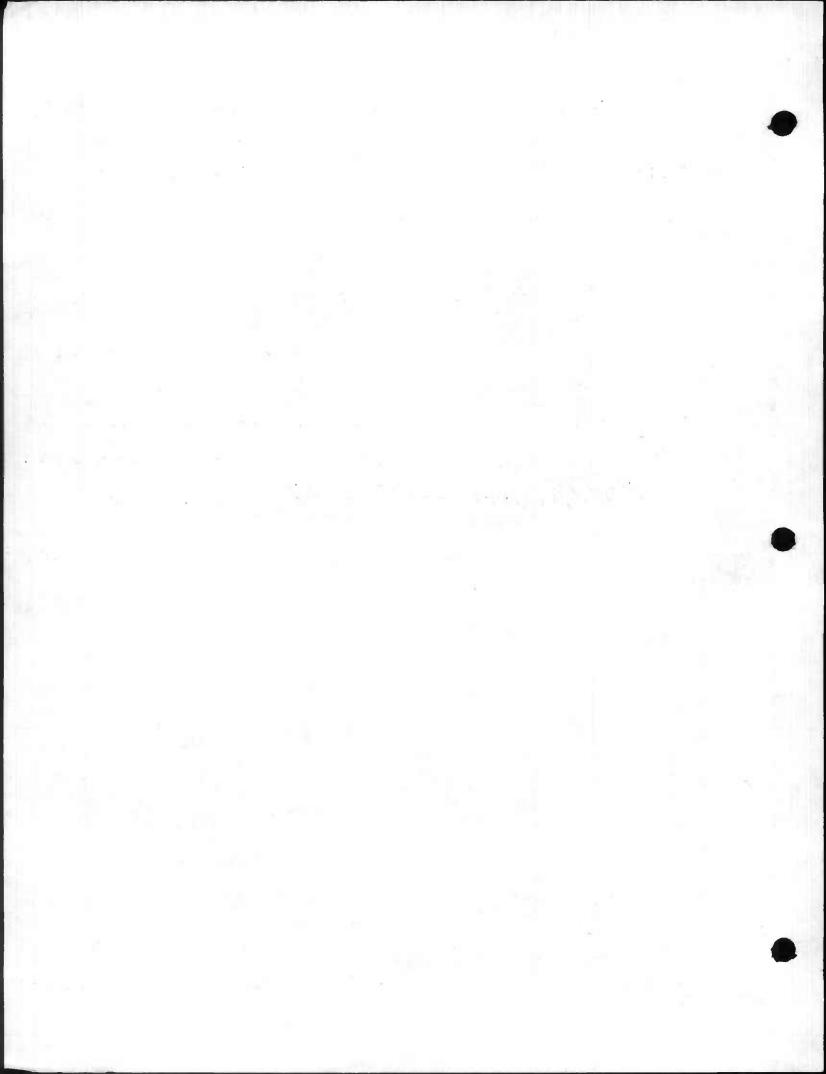
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 3 7 9 5 8

				Cei	rtificate of	Death	Re	ig. No.	01300	
		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Deat Month		3. Tima of Death	
Physician /Medical		Milton	Mc	QUAY:		Novembe		999 11:25 PM		
	edicai miner	4a Facility Name (If not institution, gi	LeRoy			4b. City, Town, o	r Location of Death	4c. County of		
LAU		9603 Cafoxa Dr	ive			Willi	amsport	WASHIN	NGTON	
Fune	rol .			rs. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birth		Birthplace (State or Foreign Country)	
Direct			12MM 2□F 69		Months Days	Hours Mi	r. (Month, Day, Feb. 22,	Year)	Mary land	
		Usual Residence of Decedent	0.		!l		1 60.22,	1930	Mai y rand	
land land		10a. Stete 10b. County	10c.	City, Town or Lo	ocation		-		10d. Inside City Limits	
Mary	ō	MD Washing	nton	Willi	amsport				1 ☐ Yes 2.50 No	
15 28 a	Director	10e. Street and Number	,		10f. Zip Code		10	ng. Citizen of Wh	nat Country?	
with w	ā	9603 Cafoxa Dr	ilvo			795				
ath 23	by Funeral		12. Was Decedent Ever in	11.0			(Saarita Van as Na	USA 14 Page	- American Indian,	
to de	5	1 t. Marital Status	Armed Forces?	10,5.	If Yes, specify Cubi	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		White, etc.	
20 at 20	> T	1 ☐ Never Married 2 € Merried 3 ☐ Widowed 4 ☐ Divorced			1 ☐ Yes 2 MNo	Specify:		Specify:	White	
OO UNDOUGH	Q Q			955						
1215-0020 within 72 hours after death with the Maryland see. than "natural", or Items 23s or 28s-1 show	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup kind of work done	during most of w	rorking	16b. Kind of Busi	ness/Industry	
で 事 。 事 。 事	d d	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	,		0.661		
filed v Hygie Hygie	ပိ	12	0	Sa	les Repre				Machine Sales	
D de la la la la la la la la la la la la la	e e	17. Father's Name (First, Middle, Las	•				ame (First, Middle, A			
should be and Mental marked o	2	John Milton	McQuay			Louis	e Matild	a Mayne	eW .	
Maryland 21215-0020 to 2 should be filed within 72 hours aft this and Mental Hygiene. The marked other than "natural", or traumatic event, the state Earth of the control o		19a. Informant's Name/Relationship					Rural Route Number			
ore, M es 1 end 2 of Health them 27 in		Dorothy M.McQuay	Wife			a Drive	Williamsp	ort, MD	21795	
Or Henry		20a. Method of Disposition		 Place of Dispo cemetery, crer 	sition (Name of matory or other place	ce)	Date	20c. Location - C	ity or Town, State	
imor Peges nent of I		1 Burial 2 □ Cremetion 3 [4 □ Donation 5 □ Other (Speci	ify)	reenlawn	Memorial Pa	ark Novemb	per 16,1999	Williams	sport, MD 21795	
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hypiene. Important: If them 27 is marked other than "natural; or item 23a or 28a-1 show any injury or other traumatic event, the Maries Institute or other profiled Inc.	<u>e</u>	21. Signature of Funeral Service Lice	0000 A 1	22	2. Name and Addre	ss of Facility			•	
m sais	DUCE	> ///w/n ///	Wales	8	SBORNE FL	JNERAL H	IOME	MD 21	705	
		23a, Part1, Entwode disease, or con	nolications that caused the de				liamsport		Approximate	
		23a. Part1. Enter the disease, or conshock, or the tailure. List only	one cause on each line.		.,,				Intervat Between Onset and Deeth	
Physicia /Medic		Immediate Cause (Final							MI	
Examin		disease or condition resulting in death)	a	e lung Comcer.						
	1		Due to	(or as a consec	quence of):					
be sit	edicai Examiner		b							
is, P.O. Box 68760, as that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	хал	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a consec	quence of):					
50, be e	<u>=</u>	cause. Enter Underlying Cause (Disease or injury that initiated evants	C							
68760, ricata be ex physician as the burial	dic	that initiated evants resulting in death) Last	Due to	(or as a conseq	luence of):				t	
ing is	Me		d						l .	
deeth cert deeth cert de attending ed for use	Physician		U						1	
.O. the de y the a	/sic	Part II. Other significant conditions	contributing to death but not a	resulting in the u	nderlying cause giv	ven in Part I.	23b. Did to	bacco use cont	ribute to the cause of death?	
P.O. thet the ed by the detached	Phy						10XY	s 2□ No 3	3 Probably 4 Unknown	
S, the second	by						- /			
Records, he lew requires t e has been signe age 2 should be	pe						24a. Was a		24b. Were autopsy findings available prior to	
lew rules be a 2 sh	De						-		completion of cause of death?	
I Re lev The lev	Completed						1 🗆 Ye	s 2DNo	1 ☐ Yes 2 ☐ No	
Vital Ilcian: The certificate rector, pag	BeC	25. Was case referred to medical				26 Place of C	eath (Check only on	e)		
of Vita Physician: this certific ral director,	0	examiner?	Hospitel: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	ier _	Home 5 Reside		(Snacihi)	
Phys of rithis praid	=	27. Manner of Death	28a. Date of tnjury	28b. Time of			28d. Describe ho			
Afte Afte	tio	1 Natural 5 Pending Investigation	(Month, Day Year)	Injury		rk? Yes 2 □ No				
VISION Attending or death. ector: After by the fune	ES E	3 Suicide 6 Could not I	De Diese of Injury A	t home ferm str	met factory office		28f. Location (St	reet and Number	r or Rural Route Number,	
Division i or Attending after death. Director: After d in by the fune	Certification:	4 Homicida determined	building, etc. (Spe	icify)	out, realtry, amou		City or Town			
pital ours filled	0	29a. Certifier Certifying P	hysician: To the best of my k	racudadas daeth	n annumed at the time	no data and als	es and due to the er	wools) and many	nor on stated	
Hospital 24 hours Funeral etely filled	edicai	(Check only one)	miner: On the basis of exami and manner steted.	ination and/or in	vestigation, in my o	ppinion, death oc	curred at the time, de	ate end place, ar	nd due to the cause(s)	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of dentitier 1	and marrier stated.		29c. Licens	e number	2	9d. Date sinned	(Month, Day, Year)	
5.25.8			1		7	, N	2	11 1 -	- 100	
		Thurdt	10hind	an M) D4	641	5	11/15	177	
		30. Name and address of person who	completed cause of death (II	tem 23a) (Type,				- 1/10		
		HING Hamda	V 1811>'		363 S	. Clevel	and Ave.H	agerstov	vn, MD 21740	
	State	31. Date tiled (Month, Dey, Year)	32. Registrar's Sig	pnature 6	Ann V	11				
Reai	strar	MANTON	/	/	Land Control	2/				



State of Maryland / Department of Health and Mental Hygiene Q

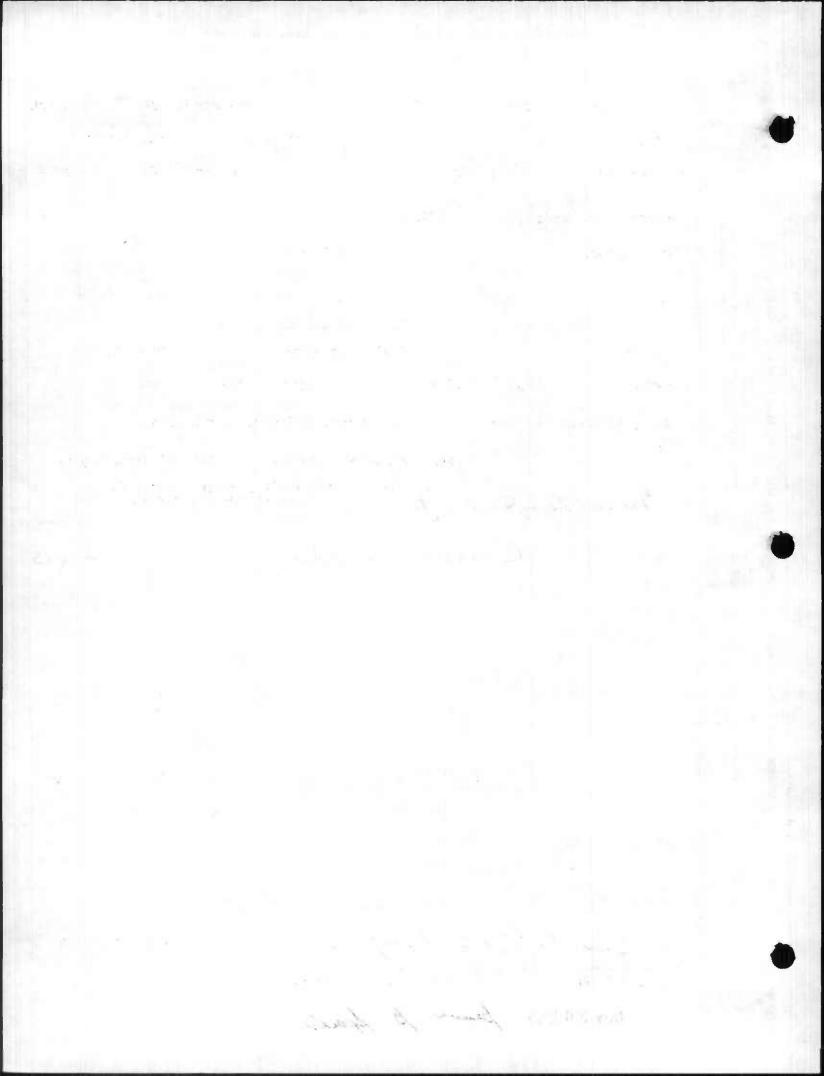
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 17, Year **Physician** Mary Thelma Norris 1999 1:44 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 578 22 3188 1 M 7€7F 75 Yes Director March 7, 1924 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD P.G. Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2327 Iverson Street 20048 United States death v Funeral Heme 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or has any injury or other traumatic notations. 1 Yes 2 No If Yes, Give X Year or Dates: Never Married 2 Married 1 Yes 2 No Specify: Baitimore, Maryland 21215-0020 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dept. Elementary/Secondery (0-12) College (1-4or 5+) Legal Secretary U.S. Government Justice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 30 2 Francis V. Norris Jane T. Raley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank V. Norris (BROTHER) 8611 Old Branch Ave, Clinton, Maryland 20735 20b. Placa of Disposition (Name of cemetery, crematory or other place) Nov 22,1999 20a Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 7C SHOCK disease or condition resulting in death) Examiner Physician/Medical Examiner RUSEPSI physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No road num m signed t Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 2 00 No certificate Division of Vitai Hospital or Attanding Physician: 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of After 1 (Watural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, tarm, atreet, tactory, offica building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) a Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier completaly (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surretts Rel # 307. Christin, MD 20735 Suresh A. Patchon 7501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene 99 37960

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Funeral Director	5. Sociel Security Number 218-52-7422		9X □M 2X0 F	7. Age (In yrs. 68	last birthday) Yrs.	If Under Months			24 Hrs. Min.	8. Date of Birt (Month, Da January	24, 1931	9. Birth	place (State or F	
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d and	2000	b. County			ty, Town or Lo								10d. Inside City I	
of of	Maryland	St. Mary'	S	H	boowllc								1□ Yes 2	
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netural; or leans 23a or 28a-f show deal Examiner must be notified at steed by Funeral Director	1 ☐ Never Married 3 Ø Widowed 4 □		1 Tes If Yes, Giv Yeer or De	2/□ No		1□ Yes			, i deito	ribari, oto.)	Specif	1.16	ite	
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	17. Father's Name (Firs	st, Middle, Last)				18. Mother's Name (F			(First, Middle,	Maiden Sumar	ne)			
Mental I harked out	Herbert	Wi	lliam Miles				Edith M			May	Hancox			
marke umaric	19a. Informant's Name	/Relationship (7	vpe. Print)		19b. Maiti	na Address	s (Stree	t and Numbe	r or Run	al Route Numbe	er, Cify or Town	State, Zij	p Code)	
Tract tract	Anthony Will									Maryland		,,		
Haaith Mher tr	20e. Method of Disposi		3 (0011)	20b.	Placa of Dispo	osition (Na	me of			Date	20c. Location	- City or To	own, State	
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Department important any injury once.	4 Donation 5 D			St	. John's			ess of Facilit		1/2//199	9 Hollyw	00d, M	laryland	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death 21, 1999 Month **Physician** Mabel Marie Needy 4:10 a.m. November /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Washington County Hagerstown Colton Villa Nursing Center 5. Social Sacurity Number 218-09-7815 8. Data of Birth (Month, Day, Year)
Oct. 22,1915 If Undar 24 Hrs. If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Funerai Days 84 Yrs. Months 1 □ M 210 F Hours Director Maryland Usual Rasidanca of Dacedant Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. 10a. Stata 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at 10d. Insida City Limits Hagerstown MD Washington Co. 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 21740 750 Dual Highway Funerai 12. Was Dacedant Evar in U,S. Armad Forcas? Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yas, Giva 1 Navar Marriad 2 Marriad 0 1 Yas 2X No Specify: White þ 3 Widowad 4 Divorced Year or Dates: Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry al Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Automobile Dealership Secretary 9 0 17. Fethar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is merked oth any Injury or other traumetic event 18. Mothar's Name (First, Middla, Maidan Surnama) Be Blanche Trumpower Cecil Charles McAllister 2 19e. Informant's Name/Relationship (Typa, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3829 Burkittsville Rd., Knoxville, Maryland 21758 Joyce Anderson/Sister 20b. Placa of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata t Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Nov.23 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 uncho + luy Part 1. Enter the disease, or compilations that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tellura. List only one ceuse on each line. Approximata Intarval Batwaan Onsat and Death **Physician** Immediata Cause (Finel disaasa or condition resulting In death) /Medical . Metastatie Bread cancer 24eas Examiner ferileme Examiner ener 24 ears Hospital or Attending Physician: The law requires that the death certificate be executed use es the burial-transit Sequentially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that Initiatad events rasulting in daath) Last and the attending physician Physician/Medicai Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ Be Completed 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy parformad? 2000 certificate 1 ☐ Yes 1 ☐ Yas 2 ☐ No 25. Was cese referred to medical examiner? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 ☐ Yas 2 ☐ No within 24 hours efter deeth.

To the Funeral Director: After this of completely filled in by the funeral director. 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) Certification: 28c. injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred 5 Panding invastigation 1. Natural 1 Yas 2 Accidant 3 Sulcida 6 Could not be datemined 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examinar: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and menner stated. Medical 29a. Cartifiar To the 29b. Signatura and titla of cartifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Year)

11-21-99

368 MILL STREBT HARBES TOWN MD 21740

State Registrar MANZAR

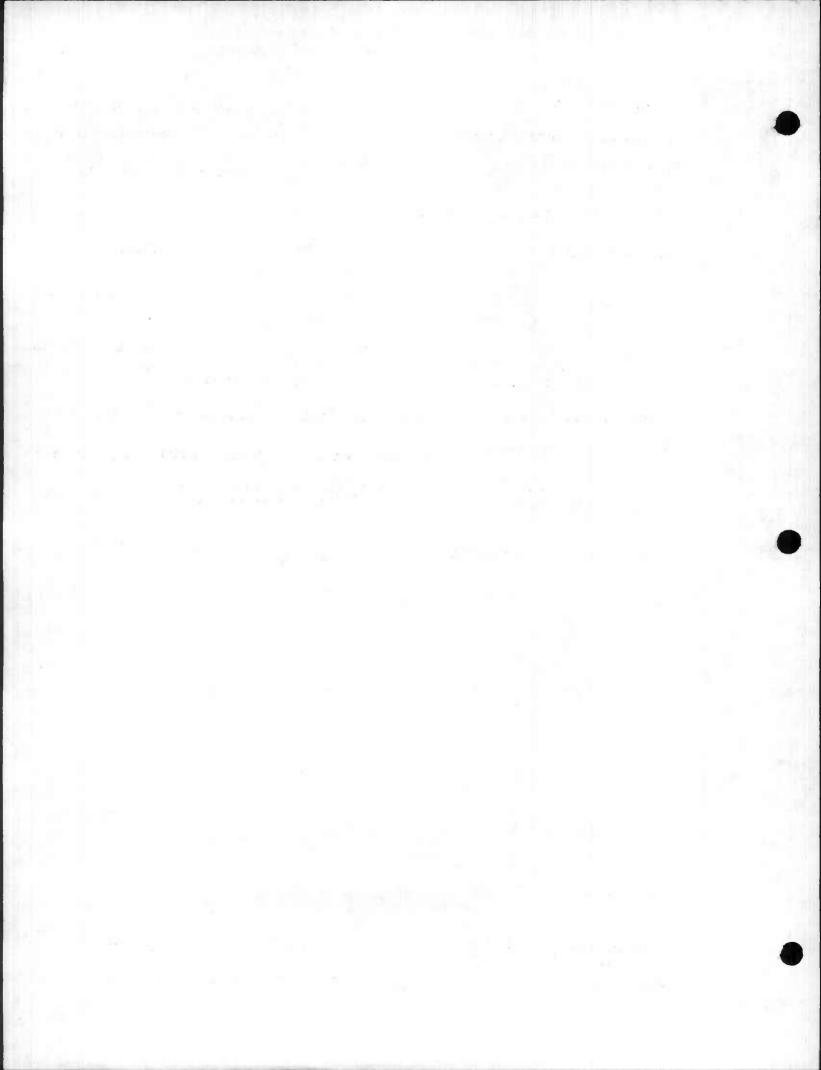
31. Data filad (Month, Day, Yaar) NOV 2 3 1999

30. Nema end address of person who completed causa of death (Item 23e) (Type, Print)

J SHAP

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



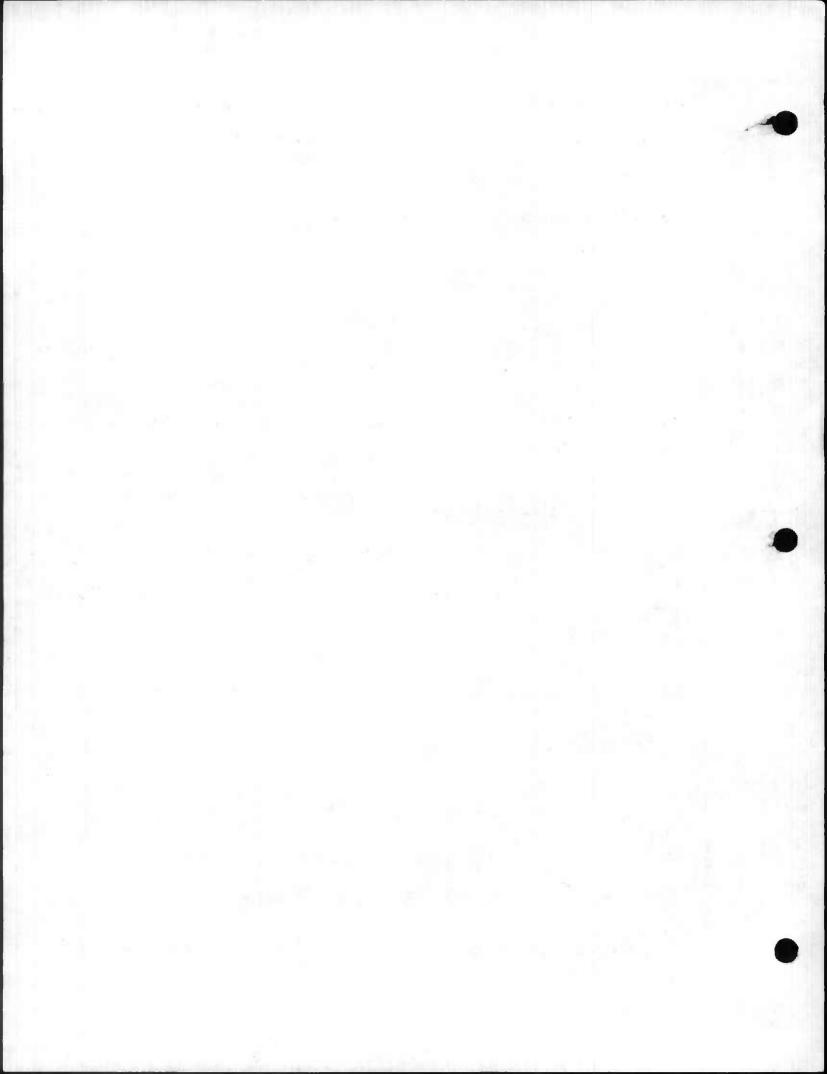
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	 Decedent's Name 	e (First, Middle,	Last)					2. Dete of De	eath		3. Time of Death	
ysician		NETTIE		R.		OKIN		Month NOVEMB	Dey	Year L999	3;00 P.M.	
lical	4a Facility Name (/		rive street and nur			OKIN	4b. City, Town, or				5,00 F.M.	
miner			N HEBREW				ROCKVI	TID		ONTGO	VEDV	
al	5. Sociel Security N		Sex 37	7. Age (In yrs.	lest birth	day) If Under 1 Yea	r If Under 24 Hrs	8. Data of Bi			lace (State or Foreign try)	
or	578-01-2		1□ M 2□ F	92	Y	Months Dey	s Hours Min.	OCTOBE	R 10,07	UI	KRAINE	
	10a. State	10b. County		10c. Ci	ty, Town	or Location				10	0d. Inside City Limits	
Director	MD	MONTGO	MERY				KVILLE				1 XYes 2 No	
Dire	10e. Street and Nur					10f. Zip Code			10g. Citizen of V	What Coun	try?	
	6105-MON	TROSE RO		alant Constant	10	10 Mar Dandari of	20852	anaih. Van an N		D STA		
by Fur	11. Marital Status1 ☐ Never Marri3 ☒ Widowed	ied 2 Married	Armed Fo	2 (XNo /e	,,5.	13. Was Decedent of If Yes, specify Cu		to Ricen, etc.)	Specify	ace - Americen Indian, lack, White, etc.		
eted	(Spec	15. Decedent's	Educetion grade completed)		16a. [Decedent's Usual Occ Give kind of work don	upation e during most of wo	rking	16b. Kind of B	usiness/Inc	dustry	
Completed	Elementary/Secondary (0-12) College (1-4or 5+)				, '	ife. DO NOT use retii SALES	7	PRIVA	ann.	INDUSTRY		
Be Co	17. Father's Neme		st)				me (First, Middle	, Maiden Suman		THOOTIVI		
OB	HAR	RY RUBI	IN				FR	EDA BA	RSKY			
	19a. informent's Na		(Type, Print)		19b. I	Malling Address (Stre				State, Zip	Code)	
	ALLA		OKIN			01-GROSVEN	OR PLACE,	ROCKVI				
	20a. Method of Disposition 120 Suriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					HEZ SHALC	position (Name of remetory or other place) EZ SHALOM 1999 20c. Location - City or Town, St WASHINGTON, D					
	21. Signal of Funeral Service Licensee 22. Name and Address of Facility STEINS HEBREW MEMORIAL CHAPET 232—CARROLL STREET, NORTHWEST WASHINGTON, D.C. 20012											
al Examiner	sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate rrying injury	b	Due to (d	or as a co	onsequence of):						
Physician/Medical	that initiated events resulting in deeth) I	Lest	d	Due to (c	or as a co	nsequence of):						
nysic	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.						given in Pert I.		Yes 22 No		the cause of death?	
by Pt		DIAG	etes i	MELL	1705				1 108 GE NO	3 P F 101	Jacoby 4 Olikilown	
Completed b	DIAGETES MELLITUS IDEOPATHIC THROMBOCYTOPENIC					ic Pupp	PURPURA 24a.			av	ere autopsy findings ailable prior to mpletion of cause deeth?	
So								10	Yes 22 No	10	Yes 2□ No	
Be	25. Was case refer exeminer?	^	Hospital:				Mhan a	ath (Check only				
P.	1 Yes 2					patient 3L DOA		T	how injury occur		y)	
Certification:	27. Manner of Death Thatural 5 Pending 28e. Date of Injury 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury 28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury 28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury 28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury 28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury 28d. Des							(Street and Numi	and Number or Rural Route Number,			
edical Cer	29a. Certifier	Certifying 2 Medical Ex	Phyelofan: To the amfner: On the ba	best of my kno	owledge,	death occurred at the or investigation, in my	time, date and plece opinion, death occu	e, and due to the	ceuse(s) and m	anner as s	teted. o the cause(s)	
-	29b. Signature end	title of certifier				29c. Lice	29c. License number			29d. Date signed (Month, Dey, Year)		
- 1	P (?	Teur	as M	D.		D 3	6552		MOVEMBER 14' 1999			
- 1												

108 1 5 1838 Summer G. Speaker

State of Maryland / Department of Health and Mental Hygiene 99 3796

		Certificate of	Death	Reg. No.	3/903		
	Decedent's Neme (First, Middle, Last)	TELESTIC	2. Dete Mon	of Death	3. Tima of Death		
Physician /Medical	Betty Jean O'BRIEN			ember 21, 199			
Examiner	4a Facility Neme (If not institution, give street and number)		4b. City, Town, or Location of	Death 4c. County of De	eth		
	Coffman Nursing Home		Hagerstown	Washi	ington		
Funeral Director	5. Social Security Number 220−16−3327 6. Sex 1 M 2 M F 7. Age (In yrs. last	t birthday) If Under 1 Year Months Days	Hours Min. 8. Date (Mon Dec.	th. Dev. Year)	irthplace (State or Foreign Country) Maryland		
pu B	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, T	Town or Location			10d. Inside City Limits		
he Maryl Sa-f aho otthed a		Smithsburg			1 ☐ Yes 2 ☑ No		
ifer death with the Manyland r heme 23e or 28e-f show inher must be notified at Funeral Director	10e. Street and Number 11200 Wolfsville Road		783	10g. Citizen of What C USA	Country?		
020 urs after ar, or he	3 ☑ Widowed 4 □ Divorced	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et Specify:	or No- lc.) 14. Race - Arr Bleck, Wh Specify:	nerican Indien, nite, etc. white		
15-002 72 hours "netural", point Earl	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent'a Usual Occu (Give kind of work done	pation during most of working ad)	16b. Kind of Busines	s/Industry		
21215-00 ed within 72 ho yojene. er than "natura n, II II Modeal Completed	Elementery/Secondary (0-12) College (1-4or 5+)		od)	physici	an's office		
offied within the wind office than want, tree was a Comp		secretary	18. Mother's Neme (First, A		III B OILICE		
yianc build be fi Mental H erked out etic aver				rnie Rummel			
aryiar should be and Mente merked umatic av		10h Mailing Address (Stree	t and Number or Rural Route		Zin Code)		
Maryland d 2 should be file th and Mental Hy 7 Is marked other traumatic avam	Timothy P. O'Brien - son		Court, Smiths				
C = M F		e of Disposition (Name of etery, cremetory or other pla		20c. Location - City of			
Baitimore, permit. Pages 1 a Department of Hei Important: If Item any Injury or othe once.	4 Donation 5 Other (Specify)	e Hill Cemete	ery 11-23	3-99 Hagerstow			
Baitim permit. Pa Departmen Important: any injury	21. Signature of Funeral Service Licensee	22. Name and Address	ess of Facility MINNI Lson Blvd., Ha	CH FUNERAL HO			
	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart feilure. List only one cause on each line.	o not when the mode of dyi	ing, such es cardiac or respire	tory errest,	Approximate Intervel Between		
Physician	and an analysis and an analysi		^		Onset end Deeth		
/Medical Examiner	Immediate Cause (Finel disease or condition	OBS muctuk	ling lises	Nel	210 Plans		
	resulting in death) Due to (or as	s a consequence of):	/		>10 gens		
Z # C	- Cone put	monale			710 years		
58760, icate be executed physician and s the burial-transit	Sequentially list conditions, if any leading to immediate	s a consequence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
6876(ficate be physicial is the bur	resulting in death) Last Due to (or es	a consequence of):					
2 00 2	d				1		
O. Box e death cer the attendir hed for use							
P.O. Box	Pert II. Other algoriticant conditions contributing to death but not resulting	ig in the underlying cause gi	iven in Pert I. 23b	o. Did tobacco use contribu			
ds, P.O. Box lies that the death certissigned by the attendin d be deteched for use d by Physician/N	CAPTERS MELLIUS			1 Yes 2 No 3	Probably 4 Unknown		
COL requi	Congestive heart faile	url	248	. Wes en autopsy performed?	b. Were autopsy findings available prior to completion of cause of death?		
Re law ha law e has age 2	V			1 Yes 2 No	1 ☐ Yes 2 ☐ No		
	25. Wes case referred to medical		26. Place of Death (Qheck	330	10 163 2010		
Of Vita Physician: this certific al director,	examiner? Hospital:	VOutpatient 3□ DOA Ot	hos /	Residence 6 Other (Sp	nacity)		
	27. Menner of Death 28a. Date of Injury 28	3b. Time of 28c. Inju		scribe how injury occurred	recity)		
Ion Ith.	1 Stretural 5 Pending (Month, Day Year) 2 Accident investigation		Yes 2 No				
Division of standing P as after death. The Director: After to die in by the funeration: Certification:	3 Suicide 6 Could not be	, farm, street, fectory, office	281. Loca	ation (Street and Number or I	Rural Route Number,		
Die din din din din din din din din din din	4 Homicide building, etc. (Specify)		City	or Town, Stete)			
DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Furneral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled (Check only one) 1 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the ti and/or investigation, in my	ime, date end place, and due to opinion, death occurred at the	to the cause(s) and manner time, date end plece, and d	as stated. ue to the cause(s)		
o the o the omple	29b. Signature and title of certifier	29c. Licen	se number	29d. Dete signed (Mo	onth, Day, Year)		
F ≱ F 8	SAMUEL CLAN MI)		6655	nov. 22	: 1999		
	30. Name and address of person who completed cause of death (term 23				/		
	1185 MT Actor Rd HACSD	STOULA	10 2174	40			
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	6					
Registrar	NOV 2 2 1999	p. spon	421				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death November 1999 John Thomas Olsen 2:45 A.M. 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 25335 Springdale Ave. Cas cade Washington If Undar 24 Hrs. 7. Aga (In yrs. last birthday) If Undar 1 Yaar 9. Birthplaca (Stata or Foraign 1 M 2 □ F Davs Hours 50 Yrs Maryland 10c. City. Town or Location 10d. Insida City Limits Washington Cascade 1 Yas Z No 10f. Zip Coda 10g. Citlzan of What Country? 25335 Springdale Ave. 21719 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yaa or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian. Black, Whita, atc 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify. Specify: White 3 Widowad 4 Divorced

16b. Kind of Business/Industry

18. Mothar's Nama (First, Middla, Maidan Sumama)

Mary Louise Schildt

Data

19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 25335 Springdale Ave. Cascade, Md. 21719

Railroad

20c. Location - City or Town, Stata

Rouzerville, PA

12525 Bradbury Ave.

16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired)

Harbaugh Cemetery Nov. 16,1999

22. Nama and Addrass of Facility

Engineer

20b. Place of Disposition (Nama of cematary, cramatory or other place)

Funeral Director

Physician

/Medical

Examiner

5. Social Security Numba

10e. Street and Number

10a State

Md.

218-50-4688

Usual Residence of Decedant

Elemantary/Secondary (0-12)

17. Fathar's Nama (First, Middla, Last)

Sharon F. Olsen

Signature of Funeral Service Lib

20a. Mathod of Disposition

Clifton Everett Olsen

19a. Informant's Name/Ralationship (Type, Print)

5 Other (Specify

10b. County

15. Dacadant's Education (Specify only highast grada complated)

Collega (1-4or 5+)

(Wife)

28a-1 show treumetic event, the Medical Examiner must be notified at ò itams 23a 6 "naturef".

by Funeral Director

Completed

Be

P

Pages 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiane. pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: if item 27 is marked other than "any injury or other treumetic event," and other pages.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

> Examiner ettanding physician for use es the buna Physician/Medical been signed by the should be detached þ Completed page 2 s Be Certification: To within 24 hours after death.
>
> To the Funeral Director: All completely filled in by the fu

or Attending Physicien: The law requires that the death certificate be executed

certificate

After this

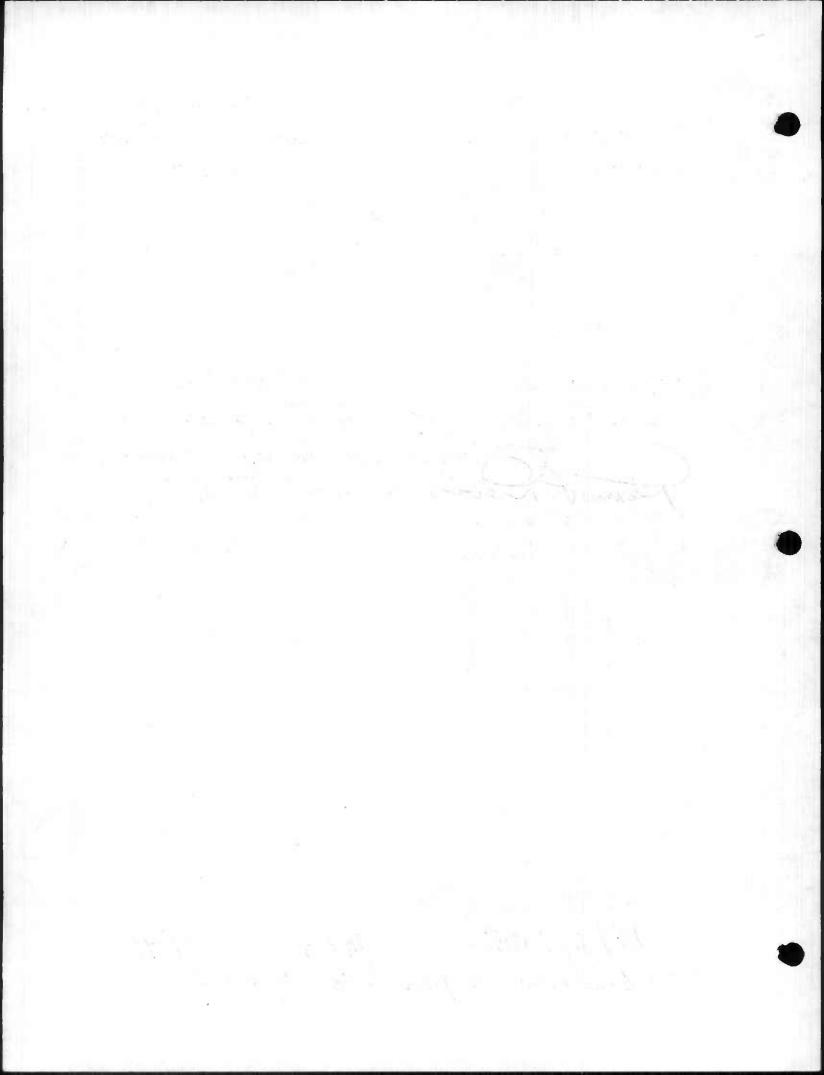
the Hospital

Division of Vital Records, P.O. Box 68760,

Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haert failure. List only one cause on each line. Immediata Cause (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to Immadiata causa. Enter Undarfying Causa (Disaese or Injury that Initieted avents rasulting In deeth) Last Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy parformad? 24b. Wara autopsy findings available prior to completion of cause of death? 1 □ Vas 2PTNO 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical 28. Piece of Deeth (Check only one) Othar: 4□ Nursing Homa 5 □ Rasidance 6 □ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daath 28b. Time of 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Steta) 28e. Piace of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homleide 1 Certifying Physician: To tha best of my knowledge, daath occurred at the time, data and place, and due to the ceusa(s) and menner es stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, data and place, and due to the causa(s) and mannar stated. Medical (Check only one) 29b. Signatura and title of certifia 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 30. Name sa of death (Item 23a) (Type, Print)

State Registrar



7			
State of Maryland	Department of H	lealth and M	lental Hygiene

			Certificate of Dea	ath Reg. No.	
		1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey Year	3. Time of Deeth
	Physiciar /Medica	Nancy Ellizabeas	Preston	Nov 16,1999	3:53PM
	• Examine	to Facility blome /// not institution aim street and number	1	y, Town, or Location of Deeth 4c. County of Deeth inton Prince Geo	orge's
	Funeral Director	579 26 5710 1□MXXF 74	yrs. lest birthday) If Under 1 Year If Un		ece (Stete or Foreign
	pue ***	Usuel Residence of Decedent 10e. Stete 10b. County 10c.	. City, Town or Location	10	d. Inside City Limits
	r 28a-f show	MD PG	Clinton		1 ☐ Yes 2 🛣 No
	23a or 28a	10e. Street and Number 6010 Arbutus Lane	10f. Zip Code 20735	10g. Citizen of Whet Count United State	
020	urs after dee	3X Widowed 4 □ Divorced If Yes, Give 1 Yeer or Dates:	in U.S. 13. Wes Decedent of Hispenic If Yes, specify Cuban, Mex	c Origin? (Specify Yes or No- xicen, Puerto Ricen, etc.) 14. Race - America Black, White, e	en Indien, etc.
5-0	"natural",	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usuel Occupetion (Give kind of work done during t	most of working 16b. Kind of Business/Indi	ustry
21215-0020	C 1 4	Elementery/Secondary (0-12) College (1-4or 5+)	clerk	U.S. Govern	nment
pu	tal Hyger digital and the swent,	17. Fether's Name (First, Middle, Last)	18. M	Nother's Name (First, Middle, Maiden Surneme)	
yla	2 should be fend Mental I is marked of aumatic eve	Snowden Rex Brown		Daisy Barrett	
Maryland	d The	19a. Informent's Neme/Relationship (Type, Print) Shirley McKalvia (DAUGHTER)		umber or Rurel Route Number, City or Town, State, Zip e, Clinton, Maryland 20735	
Baltimore,	permit. Pages 1 an Department of Haal Important: If Item 2 any Injury or other once.	A IBURIA 21 ICREMENTON 31 IMEMOVE IROM STATE	bb. Plece of Disposition (Name of cametery, cremetory or other plece) Resurrection Cemeter	Dete 20c. Location - City or Tow y Nov 20,1999 Clinton, Mar	
Balti	permit. Page Department of Important: If any Injury or	21. Signeture of Funerel Service Licensee	22. Name end Address of Fe	ecility Lee Funeral Home, Inc 6 erry Road, Clinton, Marylan	633 Old
	Physician /Medical Examiner		death. Do not enter the mode of dying, such Pulluo to (or es a consequence of):	nay Eeuloh	Approximete Interval Between Onset end Deeth
ox 68760,	death certificata be executed e ettending physician end ed for use as the buriel-transit		to (or as a consequence of):	ue to Breant	14
Box	death ce ettendiid for usa	Pert II. Other significant conditions contributing to deeth but not	resulting in the underlying cause given in F	Part I. 23b. Did tobacco use contribute to	the cause of death?
P.0	that the death ce ed by the ettendi dateched for us.	to the sum of the sum	Todaking in the anadriying decide given in t	1 Yes 2 No 3 Prob	MILLER BANGES TO THE STATE OF T
Division of Vital Records,	The law requires that the death ce age has been signed by the ettending page 2 should be deteched for use			con	re eutopsy findings vilable prior to appletion of ceuse death?
R	The law ate has page 2			1 □ Yes 242 No 1 □	Yes 2 No
ta	centificate rector, pag		26. F	Piece of Death (Check only one)	
>	2 00	1 ☐ Yes 2 ☐ NO Hospital: 1 ☐ Inpatient		☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
ion	the une	27. Manner of Death 28a. Date of Injury (Month, Dey Yee 2 Accident investigation	28b. Time of linjury et Work? M 28c. Injury et Work?	28d. Describe how injury occurred 2 □ No	
Divis	To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: After the completaly filled in by the funeral Madical Certification.	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - building, etc. (Sp	At home, ferm, street, fectory, office ecify)	281. Location (Street and Number or Rural City or Town, State)	Route Number,
	n 24 hour ne Funera pletaly fill		knowledge, death occurred at the time, date nination end/or investigation, in my opinion,	te end plece, end due to the ceuse(s) end menner es sto , death occurred et the time, dete and plece, and due to	eted. the cause(s)
	within To the Comp		Allway 29c License numb	29d. Date signed (Month, L 11.17	ay, Year)
	(5)	30. Name and eddress of person who completed cause of death and the second seco	(Nem 23e) (Type, Print) Branch	Ave #C-101 Clintor	1 MD 2073
	State		ignature		

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decadant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death November 10 y 1999 Year **Physician** 9:08 AM Mary Jane Perry /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Prince George's Cheverly Prince George's Hospital Center 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number 8. Deta of Birth 8. Deta of Birth Day 31, 1922 On 100 6. Sax **Funeral** Months 1□ M 2√(F Days Hours Min 578-28-6669 76 Yrs. Director Usual Rasidanca of Dacedant 10c. City, Town or Location Washington the Marylani 10a. State 10b. County 10d. Insida City Limits r 25a-f show a notified at D.C. 1 Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? r then "netural", or items 23s or the Medical Examiner must be a U.S.A. 20019 517 62nd Place, N.E. Apt. #C Funeral death 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ፫/No If Yas, Giva Yaar or Detas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, Whita, atc 72 hours after 1 Nevar Married 2 Married 1 Yas 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Black þ 3 Widowad 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) filled within Hygiana. Wher then Elementary/Secondery (0-12) Collaga (1-4or 5+) Federal Government (Retired) Secretary permit. Pages 1 and 2 should be file Capariment of Health and Mental Hy Important; If Item 27 is merked othe sny injury or other traumatic event, 2008. 18. Mothar's Neme (First, Middle, Maiden Sumema) 17. Fathar'a Nama (First, Middla, Last) Mamie Epps George Dawson 19a. Informant's Neme/Ralationship (Type, Print)
Miss Yvonne G. Dawson (Niece) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 5926 Nell Lane Ellenwood, Georgia 30294 20b. Placa of Disposition (Neme of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Mount Olivet Cemetery 11/17/99 Washington, D.C. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funarel Service Licensee 22. Nama and Addrass of Facility Rollins Funeral Home, Inc. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haert failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediate Ceuse (Finel Corunama Brecot with metertwo. Se 16641 disaase or condition rasulting in death) Examiner Due to (or as e consequence of) Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cousa (Disease or Injury that Initiated evants rasulting in daeth) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): Ses USa 23b. Did tobacco was contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by t d be detach 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of daath? 24a. Was an autopsy performed? Completed peen has page 2 1 Yes 2 No 1 ☐ Yas 2XXNo certificate or Attanding Physician: funeral director Be 25. Was casa rafarrad to medical 26. Plece of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No 1 Department 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of 24 hours after death.

Funeral Director: After 1 Matural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be dataminad 3 Suicide 28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Spacify) Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide filled in Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. edicai 29a. Cartifian (Check only one) within 2, To the F 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of cartifiar sould 225077 11/11/98 30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print) Executive Nace A 502 ms 20704 mo

State Registrar

NOV 1 6 1999

Simenoldof. 61 no G

31. Date tiled (Month, Day, Year)

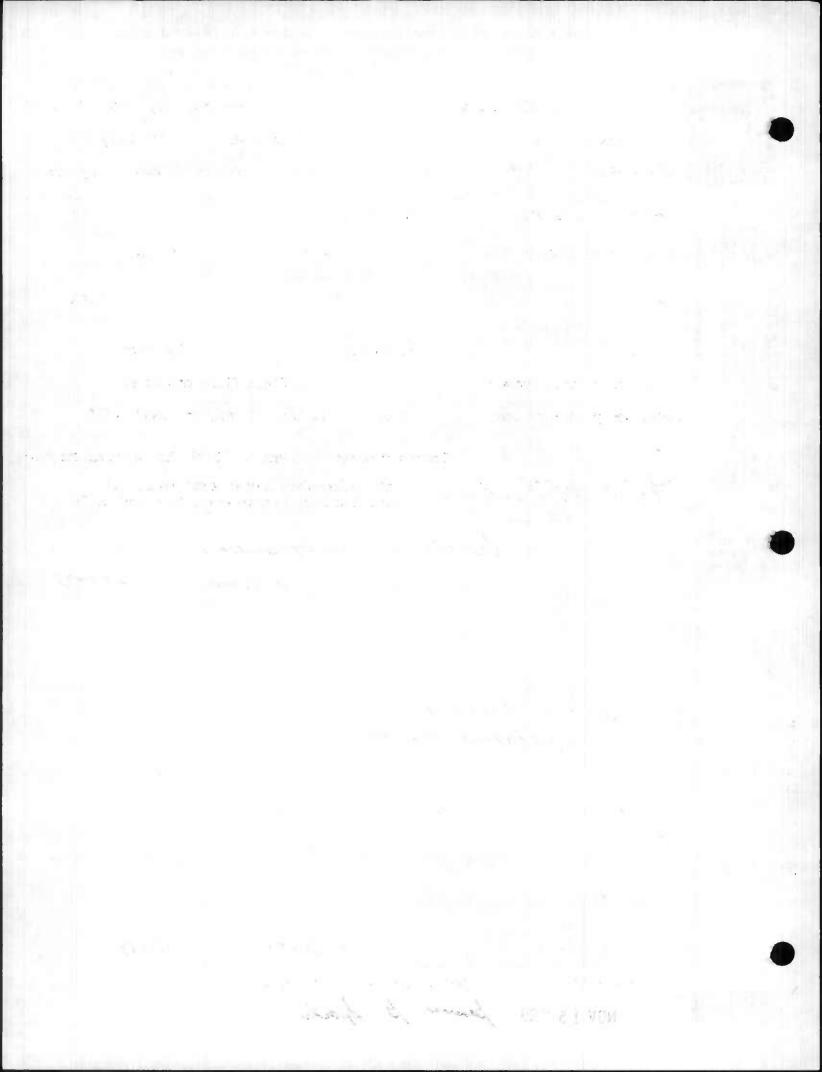
32. Registrar's Signature Sparke

7404

the state of the second second

State of Maryland / Department of Health and Mental Hygiene 99 37967

		Certificate of Death	Reg. No.	22 01301			
	Decedent'a Name (First, Middle, Last)	The second second second	2. Date of Death	3. Time of Death			
Physician	Alice Cecelia Parker		November 12	2, 1999 11:12 AM			
* /Medical Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or		County of Death			
2	St. Mary's Hospital	Leonardt	own S	St. Mary's			
Funeral Director	5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last 1 M 2 M 2 M F 7. Age (In yrs. last 1 M 2 M 2 M F 7. Age (In yrs. last 1 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	Months Days Hours Min.	Month, Day, Year) January 14,	9. Birthplaca (State or Foreign Country) Maryland			
2 .	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	2011 - 10	404 1-14-01-1-1-1-			
aryle ahov		eonardtown		10d. Inside City Limits 1 X Yes 2 □ No			
Ne M			10. 011				
itier deeth with the Mar in ferme 23a or 28=1 a infer ment be norified Funeral Director	10e. Street and Number 22495 Point Lookout Road	10f. Zip Code 20650		en of What Country?			
by by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☼ No Specify: 	o Rican, etc.)	4. Raca - American Indian, Black, White, efc. Specify: Black			
72 hd	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupetion (Give kind of work done during most of work	16b. Kin	d of Business/Industry			
be filed within 72 hor lei Hygiene. d other than "natura event, the Medical Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of worlden. DO NOT use retired) Homemaker		Home			
ent,	17. Father's Name (First, Middle, Last)	18. Mofher's Nar	ne (First, Middle, Malden S	Sumame)			
Mante Mante arked artic ev	Charles Henry Dorsey	Clar	a Elizabeth	Jones			
nd 2 should be filed within 72 hours af the and Manlei hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	19a. Informant's Name/Relationship (Type, Print) James Henry Parker/ Son	19b. Mailing Address (Street and Number or Ri P.O. Box 91, Leonard					
emit. Peges 1 en Appertment of Heal mportant: If Item 2 ny Injury or other MCs.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Disposition (Name of petery, crematory or other place)		eation - City or Town, Stata			
	21. Signature of Funeral Service Licensee Loudine 23a. Part1 Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line.	22. Name and Address of Facility Mattingley-Gardine P.O. Box 270, Ieon. Do not enter the mode of dying, such as cardian					
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or a	is a consequence of): NAY A YTEY DIS	die	Minutes			
The color day, F. C. BOX 00100, The law requires that the death certificate be assected the has been signed by the attending physician and page 2 should be datached for use as the buriet-transit completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury c	New Artry Dis	conc	- 3 rears			
daat daat ed for sicis	Part II. Other significant conditions contributing to death but not resulti	ing in the underlying cause given in Part I.	23b. Did tobecco u	use contribute to the cause of death			
es thet the death ce igned by the attend be deteched for us by Physician/	Choniz obstrat	100	1 □ Yee 2	No 3 Probably 4 Onknow			
at a far- re after death. Is after death. Is Director: After this certificate has been signed by the led in by the funeral director, page 2 should be datached. Certification: To Be Completed by Phys	Chonic obstact	isem	24a. Was an autopo performed?	sy 24b. Were autopsy findings available prior fo completion of cause of death?			
The I			1 ☐ Yes 2 Ē	TNo 1 ☐ Yes 2 ☐ No			
certificate he rector, page	25. Was case referred to medical	26. Placa of De	ath (Check only one)				
ysici is ce direc	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ El	Nursing H	lome 5 ☐ Residenca 6	Other (Specify)			
Attending Physician: r death, r death, by the funeral director, lifeation: To Be (8b. Time of linjury at Work? M 28c. Injury at Work?	28d. Describe how Injury				
tal or Attending is aftar death. al Director: Attention to the fune Certification	3□ Suicide 6□ Could not be	e, farm, street, factory, offica					
Hospi 24 hour Funer tely fill	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examiner: On the basis of examination and manner stated.						
within 2 To the comple	29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)			
	10 mester	0 36206	(1)	11/12/99			
3	30. Name and address of person who completed cause of death (Item 2 Kiran Mehta, MD Holly	3a) (Type, Print) Wood, Maryland 20636					
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatur 32. Registrar's Signatur						



Certificate of Death

Reg. No.

37968

	1. Decedent's Neme (First, Middle, La	st)						2. Dete of D	eeth _		3. Time of Deeth
Physician /Medical	Lula Gawn Poe Novem							Novembe	er 20,19	99	3:45 p.m.
Examiner	4e Fecility Neme (If not institution, give street end number)						4b. City, Town, or L				
	22680 Cedar Lane				William	1	Leonardto			Mary's	
uneral rector	379-03-3391	M 2■ F	Age (In yrs. le: 93	st birthday) Yrs.	If Under 1 Months	Deys	Hours Min.	8. Dete of Bi (Month, D Januar	y 2,1906	9. Birthple Counti Viro	ece (Stete or Foreigr ginia
3	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City.	Town or Loc	ation				*****	10	d. Inside City Limits
tariand at	Maryland St. Ma	ry's		Leonar		1					1 ■ Yes 2 □ No
r items 23s or 28s-f show what must be notified at Funeral Director	10e. Street and Number 22680 Cedar Lane	Court, A	Apt. 14	128	10f. Zip C	ode 065	60		10g. Citizen of V United		
Eraniner in by Fune	11. Meritel Stetus 1 ☐ Never Married 2 ☐ Merrled 3 ■ Widowed 4 ☐ Divorced	12. Wes Deceden Armed Forces 1 Yes 2 If If Yes, Give Yeer or Detes	s? I No		/es Decede Yes, specif		Hispenic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)	Blac	e - America ck, White, e	tc.
d other than "natural; avent, tre Mod cal Ex- Be Completed by	15. Decedent's Ed (Specify only highest gra	ducation		16a. Deced	ent's Usuel	Occup	pation during most of work	kina	16b. Kind ot Bi	usiness/Indu	istry
tra Mo	Elementery/Secondary (0-12)	College (1-4or	r 5+)	life. D	O NOT use	retire	ed)				
Co	12			Но	nemake	er			n/a		
event, Be C	17. Fether's Neme (First, Middle, Last)								e, Meiden Sumen		
To To	Ernest Alonzo C	cokman					Hannar	Connie	e Middle	ton	
traumatic To	19e. Intorment's Neme/Reletionship (Type, Print)		19b. Melling	Address (Stree	t end Number or Ru	ral Route Numi	ber, City or Town,	State, Zip (Code)
other tr	Jospeh W. Poe, Sc	n					Road, Rid			20680	
8	20e. Method of Disposition 1 ■ Burial 2 □ Cremetion 3 □		cer	ce of Dispos metery, crem r Hil	etory or oth	er ple		Dete 1-23-99	20c. Location -		
Injury B.	4 Donetton 5 Other (Specific	11/1									-
any le	TolledA	field, Jr.	,M0005	52 22	955 H	211	ess of Fecility Bri ywood Rd.	nsfield , Leon	d Funeral	1 Home MD 206	e, P.A. 650-0279
	23e. Pert1. Enter the diseese, or com shock, or heart teilure. List only	plications thet cause	ed the deeth.	Do not ente	r the mode	of dyi	ing, such es cardiec	or respiretory	errest,	t	Approximete Intervel Between
cian	shook, of flour tollars. Else only	0110 00030 011 0001	1110.								Onset end Deeth
dical	Immediete Ceuse (Finei diseese or condition	Carti	4 : 4 3	+ 1 +						7	melute
iner	resulting in deeth)	. Cardi	Due to (or	es e consequ	uence of):				-		P Comp
je je		inedi	تلمك	. 04	in ce	_				n	nonths
bunial-transit	Sequentially list conditions	b. Vo Tac				•				1	-
nal-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury										
the bu	thet initieted events	C	Due to (or e	s e consequ	ence of):		-				
or use as the buse an/Medical	resulting in deeth) Lest	d	550 10 (0) 6	v comacqu							
0	Pert II. Other significant conditions o	ontributing to death	but not result	ing in the un	dertying cau	Ise di	iven in Pert I.	23b. Die	I tobacco use co	ntribute to	the cause of death'
y Physici				_				1	Yes 2 No	s 2□ No 3□ Probably 4□ Unknow	
2 should be								24e. We	s en eutopsy formed?	com	re eutopsy tindings ilable prior to apletion ot cause eeth?
rector, page								1 🗆	Yes 2■No	1 🗆	Yes 2□ No
Be C	25. Was case reterred to medical						26. Place of Dee	th (Check only	one)		
To E	exeminer? 1 ☐ Yes 2 ■ No	Hospital: 1 Inpai	tient 2 E	R/Outpetient	3□ DOA	Ot	her: 4 Nursing H	ome 5 Res	sidence 6 DOth	er (Specify))
	27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation	28e. Dete of In (Month, D		8b. Time of Injury		. Inju			how Injury occur		
a Director: After the in by the funeral Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, term, structured building, etc. (Specify)				street, tectory, office 28f. Location (Str. City or Youn			(Street end Numb own, Stete)	(Street end Number or Rurel Route Number, wn, Stete)		
completely filled Medical Ce			ot exeminetio				ime, date end plece opinion, deeth occu				
Me	29b. Signeture and title of certifier	1/	1	~		Licen 259	se number		29d. Dete signe		

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

31. Dete filed (Month, Dey, Year)
NOV 2 2 1999

Jeffrey C. Brown, M.D., 23000 Moakley St., Leonardtown, MD 20650

DHMH 16 Rev 6/95

State Registrar at the second of the second of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene QQ

e 99 37969

							Ce	rtificat	e of	Death		Rec	g. No.		, ,	
	21		1. Decedent's Name (First, Middle, La	st)							e of Death		Vann		me of Death
	Physic /Medi		Mildred M	ay Phill	lips							OV.	16 I	Year	4.	:30 An
	Exami		4a. Facility Name (If n	ot institution, giv	e street and num	ber)				4b. City, Town,	or Location	of Death	4c. County	of Death		
			Goodwill	Mennonit	ce Home					Grants	ville		G	arreti	t	
	Funeral Director		5. Social Security Num 213-09-64. Usual Residence of De	56 ¹	ex	7. Age (In yrs 94	lest birthday Yrs.	Months	Days		Ain. (Mo	a of Birth onth, Dey, 1	^(ear) 1905	9. Birthpl Count Penns		tete or Foreign Vania
	land ww			0b. County		10c. C	ity, Town or L	ocation						10	0d. fnsi	de City Limits
	Mary Fed	to	MD	Allegany	7		Frost	ourg							13	Yes 2□No
	r 28s	Director	10e. Street and Numb	er				10f. Zip	Code			109	g. Citizen of	What Coun	try?	
	h will	a D	52 Meshac	k Frost	Village				21	.532			US	Δ		
	deet	Funeral	11. Marital Status		12. Was Deced	dent Ever in U	J,S. 13.	Was Dece		Hispanic Origini ban, Mexican, Pi	(Specify Ya	s or No-	14. Rad	ce - America		an,
21215-0020	n 72 hours efter deeth with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at	by	1 Never Married		1 Tes 2 If Yas, Give Yaar or Dat	2 № No		1 ☐ Yas			ueno Hican, i	etc.)	Specif	ck, White, e		ite
5-0	ges 1 and 2 should be filed within 72 ho it of Health and Mantal Hygians. If Item 27 is marked other than "natur or other traumatic event, the Madical	Completed	(Specify	5. Decadent's Ed	ducation		16a. Dace	edent's Usua	al Occu	upation	working	10	6b. Kind of B	usinass/Ind	dustry	
21	within lene. than	npie	Elementary/Second		College (1-	4or 5+)	life.	DO NOT u	se retin	e during most of ed)	WOIKING					
	filed within Hygiene. ither than "	Co	8 th	S (2005)			Homemaker						Home			
Maryland	should be filed nd Mental Hygi marked other imatic event, t	Be	17. Father's Name (Fit									e (First, Middle, Maiden Surneme)				
Z	should be nd Mental marked o	မ	William M								nda Bo					
Mai	12 sho h end ls me treume	1	19a. Informant's Name			0.10				et end Number o			-			- 0350
	1 end Health em 27		Dorothy E 20a. Method of Dispos		e/ daugnt		Place of Disp			.74 Mead	OWV1eW Date		Gran			
Baltimore,	Pe Pe		1 🔀 Burial 2 🗆 0 4 🗆 Donation 5	Cremation 3		tate	cemetery, cre	metory or c	ther pl	ece)						10
Bal	permit. Pe Depertmen Important: any Injury once.		21. Signature of Fune		20110-1	ru	N	lewman	Fir	ress of Facility Ineral He	omes,	P.A.,	PO Bo	ox 275	5	
П			23a. Part1. Enter the shock, or heart for	disease, or com	plications that ca	used the dea	th. Do not er	79 Mi	lle e of dy	r St.	Grants	ville ratory arres	MD	21536	Approx	ximata al Between
	Physician /Medical Examiner		Immediate Cause (Fir disaasa or condition resulting in death)		a. R	ES pi	rpto	ry_		Ailu	u			9	Onset	and Death
ox 68760,	sath certificata be executed attanding physician end for use as the burial-transit	an/Medical Examiner	Sequentially list condi if any, leeding to imme cause. Enter Underlyi Cause (Disease or int that initiated events resulting in death) Las		b. End	STAG	or as a conse	equence of):	PAR	kinsor	n`S	Kis	case	15	0	years.
œ.	the atta	sicia	Part II. Other significa	nt conditions o	ontributing to dea	th but not re	sulting In the	underlyina d	ausa o	iven in Part I.	23	3b. Dld tob	acco usa co	entribute to	the ca	use of death?
s, P.O	thet the	by Physician										1 🗆 Yes		3 Prob		4 Unknown
Records	e law requires has been sign ge 2 should be	Completed b									24	a. Was an performe		ave	aliabla p	opsy findings prior to n of cause
H	0 - 5	ь По										1 Tyes	2 No	1□	Yes	2 No
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of <	d is	2	1 Yes 2D No		Hospital: 1 In	patient 2	ER/Outpatie	nt 3 DC	DA O	ther: Nursir	g Home 5	Residen	ce 6 □Oti	ner (Specify	1)	
	After fune	1.	27. Manner of Deeth 12 Natural 2 ☐ Accident	5 ☐ Pending investigation	28e. Dete of Injury (Month, Dey Yeer) 28b. Time of Injury Work?						28d. De	escribe how	v injury occu	rred		
Division	当時前に	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	0 00 01-01-01					28f. Loc Cit	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Certifier 1 (Check only 20 one)	Certifying Phy Medical Exam	ysician: To the b niner: On the bas and manne	is of examina	owledge, lead ation and or in	th occurred vestigation	at the t	time, date end pl opinion, death o	ace, and due	e to the cau se time, det	use(s) and m e end plece,	anner as st end due to	ated. the cer	use(s)
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)	2		30 No.	_ 2		1		Jus		De	3407	79	Nov.	16		999
	0		30. Name and address		completed course	of death (Ite	m 23e) (Type	, Print)		1 1	1 5	2.	21:	52/		
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W. W.

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Year **Physician** Virginia Dorothy Reamy November 15, 1999 2:50 am /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7144 Presley Road Lanham Prince George's If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Sociei Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Deys Hours Months 1□M 2XF Yrs. 86 Director 577-36-5691 Aug. 9, 1913 Virginia Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itema 23a or 28a-f ahow poicel Examiner must be notified at 1 X Yes 2 No Director Prince George's Maryland Greenbelt 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 14-E Hillside Road 20770 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours aftar 1 Never Merried 2 Merried 1 ☐ Yes 2 No If Yes, Give 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 X Widowed 4 ☐ Divorced White Yeer or Dates: al Hygiena. I other than *natura ivent, the Mexical E Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Aviation Elementary/Secondary (0-12) College (1-4or 5+) 12 Administration Government Worker Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other treumatic event appea. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Richardson Evelyn Luther Alexander 19e. Informent's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kenneth A. Reamy - Son 4900 Sudley Choice Lane, Harwood, Maryland 20776 20b. Place of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetory or other place) 1 Burial 2 □ Cremetion 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 11/17/99 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gasch's Funeral Home, P.A. alle. a. asc 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heer tailure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in death) CARCINOMA OF THE COLON Examiner Due to (or es e consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last Due to (or es a consequence of): P.O. Box 68760, physician s the buria Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARCINOMA OF THE UTERUS Records, þ 50 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Daughter's Hospitel: Certification: To 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this Residence 28a. Dete of tnjury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 XNetural after death. 1 ∏ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide filled in 24 hours a Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the casts of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) 29b. Signeture and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) D19431 November 17, 1999 30. Neme and address of person with comp d cause of death (tem 23a) (Type, Print) 11/01 Livingstone Road, Suite #203, Ft. Washington, MD 20744 Frank M. Ryan, M.D., 31. Dete filed (Month, Dey, Year) Registrer's Signeture State NOV 1 9 1999 Registrar Banker

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 37971

						Certifica	ate of	Death		Reg. No.		
	Physic /Medi		Decedant's Nama (First, Middla, L JOHN	ast)		R	ILEY		2. Data of D Month	eath Dey	Yaar 1999	3. Time of Death 7:30 am
	Exami		4a. Facility Nama (If not institution, g 12610 STURDEE					4b. City, Town, or IPPER M.	Location of Dea	th 4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 6. 250–48–7677 Usual Rasidance of Decedant	Sex 7. Ag 12 M 2□ F	a (In yrs. la: 67	Yrs. If Unc	dar 1 Yaar s Days	If Undar 24 Hrs Hours Min		irth 1932	Соц	place (Stata or Foreigr intry) h Carolina
	Maryland a-f show	tor	10a. Stata 10b. County	George's		Town or Location per Marlbo	oro					10d. Insida City Limits
	ith with the Maryla 23a or 28a-f show	Funeral Director	10e. Street and Number 12610 Sturdee Dri	ive		10f. i	Zip Coda 20	772		10g. Citizen of U.S		ntry?
020	or items	by	11. Marital Status 1 Nevar Married 2 Marriad 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas? 1 X Yas 2 1 If Yes, Giva Yaar or Datas:		13. Was Dec If Yas, sp	edant of Hoecify Cubs	lispanic Origin? (S an, Maxican, Puar Specify:	Specify Yas or N to Ricen, atc.)	o- 14. Ra Bi	ack, Whita,	ican Indian, , atc. Black
Maryland ZIZIS-00Z0	- 1	Be Completed	15. Decedant's E (Specify only highast g	Education rada complated)		16a. Decedent's U:	suel Occup	ation during most of wa	rking	16b. Kind of	Businass/Ir	ndustry
717		ошо	Elementary/Secondary (0-12) 6th	Collega (1-4or 5	5+)	(Giva kind of work dona during most of work life. DO NOT use ratired) Laborer				P	Private	
2	12 should be filed w h and Mental Hygiel I is marked other the traumatic event, the	Be	17. Fathar's Nama (First, Middla, Las	t)					ma (First, Middle	a, Meiden Surna		
y ic	d Men d Men marke	70	Murphey Riley	The Original		401 14-11	'0		(UnKnow			
3	Ith an 17 is r		19a. Informant's Name/Ralationship Sabrina Riley-Co		nter	19b. Mailing Addres						yland 2077
palillinore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than may fajury or other traumatic event, the Mande.		20a. Method of Disposition 1 Buriel 2 Cramation 3 4 Donation 5 Othar (Spec	Ramoval from Stata	20b. Placen	ca of Disposition (A natary, cramatory o and Veterar	lama of r othar plac	ce)	Data 11/22 1999	20c. Location	- City or T	
Dall	permit. Departm Importa eny inju		21. Signatura of Funaral Sarvice Lice	Percen	tie			ss of Facility NS FUNER ver Road		ver, Ma	rvlan	d 20785
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Causa (Final disease or condition rasulting in death)	ESOPHACE.	GEAL C							Approximeta Intarvel Batween Onset and Death
X 68/60,	certificete be executed ding physician and ise es the burial-transit	/Medical Examiner	Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Causa (Disease or Injury that initiated avents rasulting in death) Last	c	32.1	s a consequanca o						
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VIIal	ate pag	e Cor	or Western Constant Constant	i -						Yas 2X No	1	☐ Yas 2☐ No
-	Physician: this certific ral director,	To Be	25. Was case referred to medical axeminer? 1 Yes 2 No	Hospitel: 1 ☐ Inpatie	nt 2 🗆 FF	R/Outpatient 3□ I	Oth	or.	eth <i>(Check only</i> Homa 5 ऒ Ras		ther (Speci	(6,1)
	After fune	Certification: 7	27. Mennar of Death 1 X Natural 5 Pending 2 Accident Invastigation	28a. Data of Injui (Month, Dej		Bb. Time of Injury	28c. Injur Wor		T	how injury occu		97
DIVISION			3 Suicida 6 Could not 1	building, ato	c. (Spacify)	a, farm, straat, facto			City or To	wn, Stata)		al Routa Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Cartifiar 1 CartifyIng Pl (Check only one) 2 Medical Exa	hyelclen: To the best of miner: On the basis of and mannar sta	axamination	edge, daath occurre n end/or Invastigation	d at tha tin on, In my o	na, data and place pinion, daath occu	e, and dua to the urred et the time,	causa(s) and n , data and placa	nanner es s , end dua t	stated. to the causa(s)
	within 2 To the comple	Me	29b. Signatura and titla of certifiar	. 11-	0	2	9c. Licans	a number		29d. Data sign	ed (Month,	Day, Year)
			Robert 6.	Wood lee	Il		000	31411	N	OVEMBER	16,	1999
(5)1	a	30. Name and eddress of person who ROBERT G. WADLEI	GH, M.D.	VAMC,	50 IRVIN	G STR	EET NW,	WASHING	TON, DC	2042	2
	Sta Registr		31. Data filed (Month, Day, Year) NOV 1 7 199	32 Registra	ar's Signetur	4 1	11-	-				

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death November 7,1999 12:34 P.M. William T. Roeder 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Year If Under 24 Hrs. 6. Sex M 2□ F 8. Date of Birth 9. Birthplace (State or Foreign July 23, 1932 Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Months Hours 67 578-42-5127 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20817 6402 Lone Oak Drive 12. Was Decedent Ever in U,S. Armed Forces? YQAyes 2□No If Yes, Give Year or Dates: 1951–54 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried Married white 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Telephone Company Telephone Repair 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Iva F. Foreacre Charles A. Roeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6402 Lone Oak Dr. Bethesda, MD 20817 19e. Informent's Neme/Reletionship (Type, Print) Margie R. Ellis/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete XXBuriel 2 Cremetion 3 Removel from State Ft. Lincoln Cemetery Nov. 10, 1999 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme end Address of FacilityFt. Lincoln Funeral Home wells 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Politz-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Arrhythmia.

Due to (or as a consequence of): Immediete Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dreumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 PTER/Outpatient 3 | DOA Yes 2□ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide

Box 68760, P.O. Records, 58 certificate of Vital funeral director, this After Division

or Attending F after death. Director: After filled in by

Physician/Medical þ Completed 8 edicai Certification: To

Physician

/Medical

Examiner

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William

permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 Is mented of any Injury or other traumatic eve

Physician

/Medical

Examiner

To the Hospital of within 24 hours at To the Funeral D completely filled I 0 State

Registrar

29b. Signature and title of certifier If Challler 29c. License number
D42518

29d. Date signed time
NOV

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rocker wo PItce #401, Rockers of PItce #401, MB 70852

31. Dete filed (Month, Dey, Year)

NOV 1 6 1999

29a. Certifier

32. Registrar's Signature Sparke

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBET 2 13, 1999 **Physician** Eula Maye Richmond /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner REGENCY PARKWAY # 202 PRINCE GEORGES SUITLAND If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country) If Under 1 Yaar 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2점F Months 65 578-68-7112 November 14,193B Georgia Director Usual Residence of Decedent with the Marylend 10d. Inside City Limits 10a State 10b County 10c City Town or Location "natural", or items 23a or 28a-f show spical Examiner must be notified at 1 ☐ Yas 2 No Director Prince Georges Suitland [] Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 3826 Regency Parkway (apt. 202) United States death 1 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, atc.) 11. Marital Status s filed within 72 hours after de al Hygiene. other then "natural", or item 1 Naver Married 2 Marriad 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Black p 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home marked other permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oths any injury or other traumatic event, pince. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Ira James Morman Bessie Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 Yvette Peoples - Daughter 3826 Regency Parkway (apt. 202), Suitland, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from Stata 11-19-99 Brentwood, Maryland Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722 8 raus 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** . ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien end the burief-transit Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, P. signed l p 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was en autopsy performed? Completed hes 9 2 is certificate her director, pege 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 2 Accident Injury 5 Pending 1 Yas 2 No death. investigation Director: / 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours at the Funeral DI mpletely filled in Hospital 29a. Certifier (Check only one) 1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date end place, and due to the cause(s) and mannar strend. within 2 To the 29d. Date signed (Month, Day, Year) 29c. Licanse number 29b. Signature end title cause of dealty (Item 23a) (Type, Print) address of person who comple

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 6 1999

MARIO F

GOLLE

32. Registrar's Signatura

4. Spark

MO

3001 HOSPITAL

DRIVE, CHEVERLY, MARSLAND 20785

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Florence Beatrice Reed Nov.11,1999 8:30a.m. /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4508 Hiwassee Dr. Clinton Prince Georges If Under 24 Hrs. If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) B. Data of Birth (Month, Day, Year) **Funeral** Days Hours 10 M X0 F Months 223-40-1082 Director 92 Virginia June 18, 1907 Usual Rasidanca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Md. Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4508 Hiwassee Dr. Funeral 20735 U.S.A. 14. Race - American Indien, 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas ※ No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 72 hours after 1 Neyer Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black Aq 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiena. Elemantary/Secondary (0-12) UNKNOWN College (1-4or 5+) Domestic Private 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be file Department of Haaith and Mental Hy important: if item 27 is marked oth any injury or other traumatic svem Be Lulu Hill John Green 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Clifford Reed (Son) 4508 Hiwassee Dr., Clinton, Md 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stata Mt.Comfort Cemetery Alex., Va. 4 ☐ Donetion 5 ☐ Othar (Specify) 11-16 22. Nama and Address of Facility
Lewis Funeral Home of Funaral Service Licensee 311 N.Patrick St., Alex., Va. 22314 23e. Pert1. Entar the disasset or complications that caused the daeth. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. Ust only one causa on aach lina. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Causa (Final disaasa or condition rasulting in deeth) Examiner Examiner betes physician and the burial-transit Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Ceusa (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown þ Records. 24b. Ware autopsy findings available prior to Completed 24a. Was an eutopsy performed? complation of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: aftar death. Director: Aftar this cartifica Be 25. Was case rafarred to medical 26. Place of Death (Check only ona) 1 Yas 20 No Other: 4 Nursing Homa 5 Aesidence 6 Other (Specify) Medicai Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicida To the Hospital or within 24 hours aft To the Funeral Di complataly filled in 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, and due to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29b. Signetura and 29c. License number 29d. Data signed (Month, Day, Year) 0/0/053115 MID. se of death (Item 23a) (Type, Print) 30. Nema and addrass of person Little River Tumpike EVEN 32, Registrar's Signatura 31. Data filed (Month, Dey, Year)

DHMH 16 Rev 6/95

State

Registrar

NOV 1 5 1999

10V 1 5:339 Survey Street

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** NMonth NATHANIEL ROSS 99 10:20A M /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 24 Hrs. If Linder 1 Year 8. Date of Birth April 2, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign V FRUTNIA **Funeral** Days Hours 226-18-0493 1⊠M 2□ F 83 Yes Director Usual Rasidance of Dacedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at WASHINGTON 1 No Yes 2 No DC Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20002 1216 18TH STREET N.E. UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Health Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Statue 1 ☐ Yes À X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 UNEMPLOYED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN OSIE ROSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 18TH STREET NEWASHINGTON, DC EDITH ROSS/ WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-19-99 SUITLAND, MD LINCOLN MEMORIAL 22. Name and Address of Facility Dudley Funeral Home 3200 21. Signature of Funaral Service Licenti E.M. Dudley Rhode Island Ave. Mt. Rainier MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Nonknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 Yes 2 10 No 1 ☐ Yes 2 ☐ 110 certificate Division of Vitai or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 1 Natural 5 Pending in 24 hours after death.

The Funeral Director: After pletely filled in by the fun invastigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida To the Hospital o within 24 hours af To the Funeral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifier 29c. License numbe 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) oad Wheadon MD 5302 31. Date filed (Month, Day, Year) 32 Angistrar's Signature State NOV 1 5 1999 Registrar

118 15 1998 Same of Same

Box 68760. Records, P.O. Division of Vitai

physician and the burial-transit this After

Physician

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comit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Separament of Health and Mental Hyglene.
Important: If team 27 is marked other than "natural", or Nerns 23s or 28s-f show any higher or other traumatic event, the Mexical Examples mass be notified at these

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

þ Completed Be To Ne Hospital or Attending P in 24 hours after death. Certification:

Physician/Medical

Medical completely To the Vithin 2

Registrar

MARTIN

31. Date filed (Month, Day, Year)

NOV 1 9 1999

29b. Signature end title of certifier

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be determined

Maha LESIDENT

29c. License number RES-000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year) November 16, 1999

28t. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 Northwolfe Street Baltimore Mary band 21287

28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify)

32. Registrar's Signature

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104 1 2 1663

TREDRICK, MD 20639

State Registrar 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

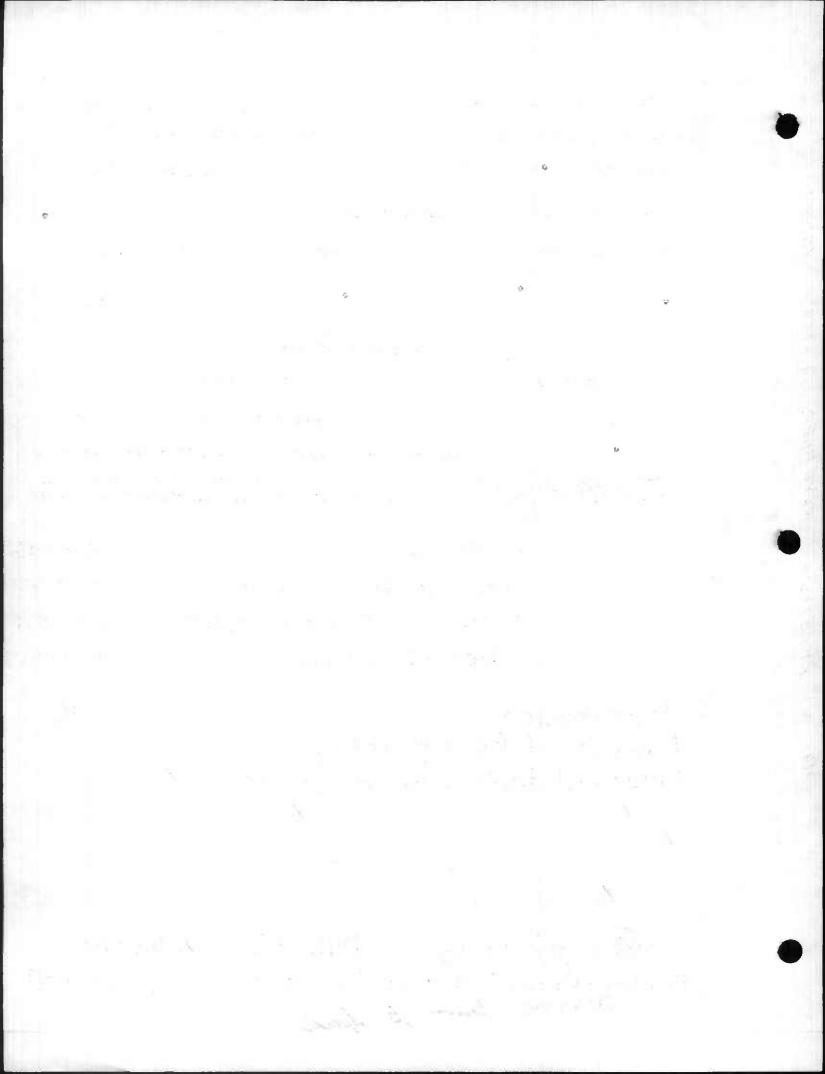
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32. Registrar's Signeture

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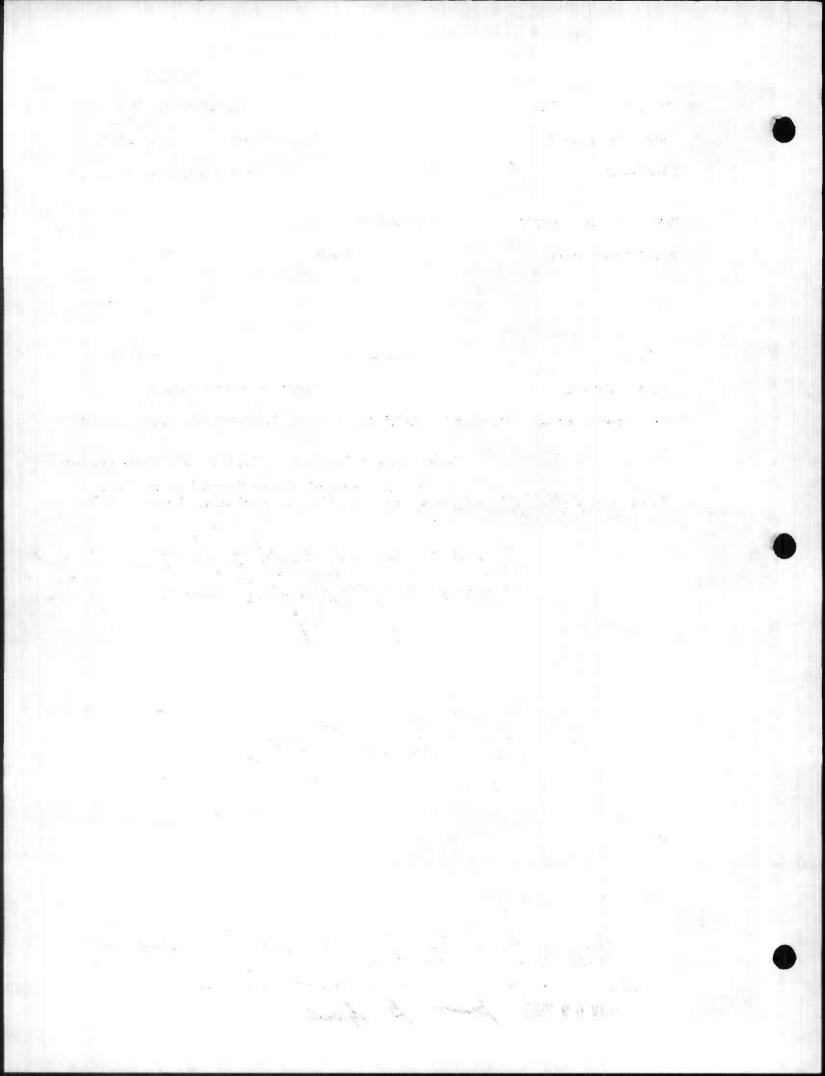


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State of Maryland / Department of Health and Mental Hygiene 0

978 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician November 6, 1999 9:00 PM Mary Jeanette Raley · /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23025 Brown Road Leonardtown St. Mary's If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2ĂF Deys 215-46-4225 94 Yrs. April 19,1905 Director Maryland Usuai Residenca of Decedent the Marylend 10a, Stete 10b. County 10c. City, Town or Location 10d. inside City Limits from 27 is marked other than "natural", or froms 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes No Directo Maryland St. Mary's Leonardtown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 23025 Brown Road 20650 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Madical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 20 3℃Widowed 4 □ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 10th Homemaker Own Home 18. Mothar's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Joseph Russell Mary Jeanette Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Jeanette Brown / Daughter 23025 Brown Road, Leonardtown, Maryland 20650 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burlal 2 Cremetion 3 Removel from State 11/9/99 Bushwood, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart Cemetery 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Servica Licensee 23a. Pert1. Enter the diseese, or complications that caused the deshock, or heart failure. List only one cause on each line. Zuchag P.O. Box 270, Leonardtown, Maryland 20650 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata tritervel Between Ogset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner ician end bunal-trans Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to for as a concertificate be execu ettending physician for use es the buna Physician/Medical Due to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 6 1 | Yes 2 No 3 | Probably 4 Unknown Division of Vital Records. þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? N.11. certificata hes 1 Yes 2- No 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only ona) Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) Hospital: 10 1 Yas 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ in A this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Netural efter deeth. Director: Af 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, atc. (Spacify) 4 Homicide 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, end due to the ceuse(s) end manner as stated.

2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Cartifian Medical (Check only one) To the F within 2 29b. Signatura and title of certifie 29d. Date signed (Month, Day, Year) f cause of death (Item 23a) (Type, Print) 30. Name and address J. Patrick Jarboe /MD Leonardtown, Maryland 20650 31. Date filed (Mr. 32. Registrar's Signature Jener Registrar



Please	Type or Print in Black Indelible ink.	Assure All Copies Are Legible.	
	State of Maryland / Department of Ho	ealth and Mental Hygiene	

ey A. Re	Certificate of Death		Reg. No.	37979
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/Medical	Rodney Allen Reeder	Novemb	1	
Examiner		or Location of Deat		
	Saint Mary's Hospital Leonar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		Saint M	
Funeral Director		Min. (Month, Da		irthplace (State or Foreign Country) Maryland
Bu .	10a. State 10b. County 10c. City, Town or Location			10d. fnside City Limits
28a-f sho notified at rector	Maryland St. Mary's Hollywood			1 Yas 2 No
be notified Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	Country?
	23532 Mervel Dean Road 20636		USA	
by Funeral	11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexicen, Pt 1 Yes Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexicen, Pt 1 Yes, Specify: 1 Yes 2 No Specify:	? (Specify Yes or No uerto Rican, etc.)	9- 14. Race - An Black, Wh Specify: W	
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Con	12th Grade Auto Body Technicia	n	Auto Body	Shop
Be		Name (First, Middle		
2	George Johnson Reeder Margar			ckler
	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number of		140	
	George J. Reeder (Father) 23532 Mervel Dean Rd	-		
	1 Buriel 2 Cremetion 3 Removel from State	Date 11 /13 /0	20c. Location - City of	
	21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Mattingley-Gardi			
8	Michael Programmer P.O. Box 270, Le			
an al er examiner	23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as can shock, or heart feilure. List only one ceuse on each line. Immediate Cause (Finel disease or condition resulting in deeth) Due to (or as a consequence of):			Approximete Intervel Between Onset end Death
Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or es a consequence of):			
Physician/M				
yslo	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f.	23b. Dld	tobacco use contribu	rte to the cause of death?
by Ph		10	Yes 20 No 3	Probably 4 Unknown
Completed			en eutopsy ormed?	Were sutopsy findings aveilable prior to completion of cause of death?
Co		100	Yes 2□No	10 Yes 2□ No
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2	XIXIYes 2 □ No Hospitel: 1 □ Inpatient XIXER/Outpatient 3 □ DOA Other: 4 □ Nursin	ng Home 5 🗆 Resi	dence 8 Other (S)	pecify)
-in	27. Manner of Death 28a. Dete of Injury 28b. Time of Injury 28c. Injury at Injury 28c. Injury at Work?	28d. Describe	how injury occurred	lauto
cation:	2 Accident investigation 11/10/99 0900 M 1 Yes 2 No	Sone	extan	ST
Certification:	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (City or To	Street end Number or wn, State) Mervell	Pural Route Number, Por PD 20631
Medical Certificat	29e. Cartifier (Check Descripting Physician: To the best of my knowledge, deeth occurred at the time, date and picture (Check Description) (Check	lace, end due to the occurred at the time,	ceuse(s) and menner date and place, and d	ss stated. ue to the cause(s)
Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
	O.C.M.E. 30. Neme and address of parson who completed cause of deeth (Item 23a) (Type, Print)		November	11, 1999
	J. LARON LOCKE MD 111 Penn Street, B	altimore,	Maryland	21201
State egistrar	31. Dete filed (Month, Day, Year) NOV 1 5 1999 32. Registrar's Signeture			

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Please Type or Print in Biack Indeiible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year Thelma Elizabeth REED 20, 1999 4c. County of Death 435 November 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1□ M 2K) F Months 225-24-0914 81 Aug. 22, 1918 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1⊠ Yes 2 No Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 West Howard Street 21740 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Merried white 1 Yes 2 XNo Specify: Specify 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 psychiatric nursing assistant hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First Middle, Last) Ollie Belle Poteet John Jefferson Perdue 19a. Informant's Neme/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 W. Howard Street, Hagerstown, Md. 21740 Sandra Plott - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 11/23/99 Hagerstown, Maryland 21. Signature of Fullerel Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervet Between Onset and Death Cardio myopathy Immediate Cause (Final 60185 diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initieted events resulting in death) Last Due to (or as a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 82 foretrion 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? Palmonar (DOON) 24a. Was an autopsy performed? 183fortune Klina 1 Yes 2 1NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 El Inpatient 3□ DOA 2 ER/Outpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

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Examiner Physician/Medical by Completed Be Certification: To

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72 hours after

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. or Attanding after death. within 24 hours a To the Funeral D

the the

Reed, Theima

27. Manner of Death 1 Natural

29a. Certifier

2 Accident 3 ☐ Suicide 4 Homicide

(Check only one)

6 ☐ Could not be

2 Medical Examiner: On the basis of exa and manner stated.

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

ination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature end title of certifie

30. Name and address of person who p

29c. License number

29d. Date şigned (Month, Day, Year)

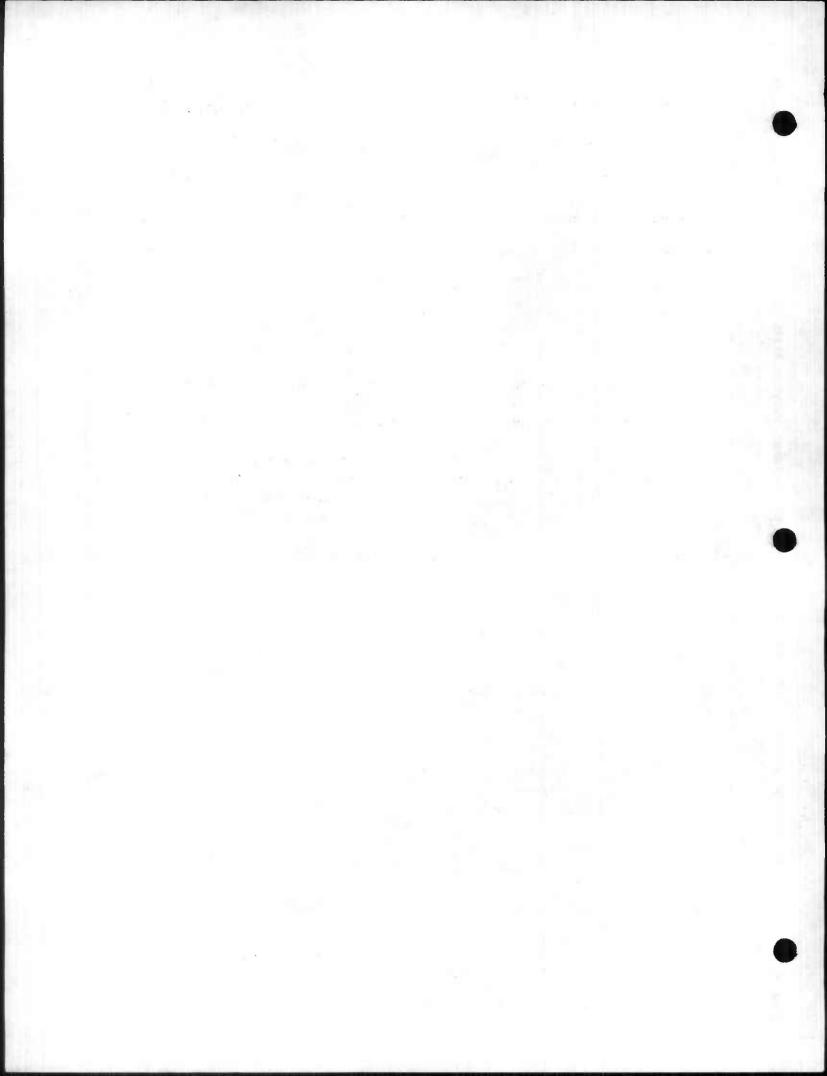
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alla (Item 23a) (Type, Rrint)

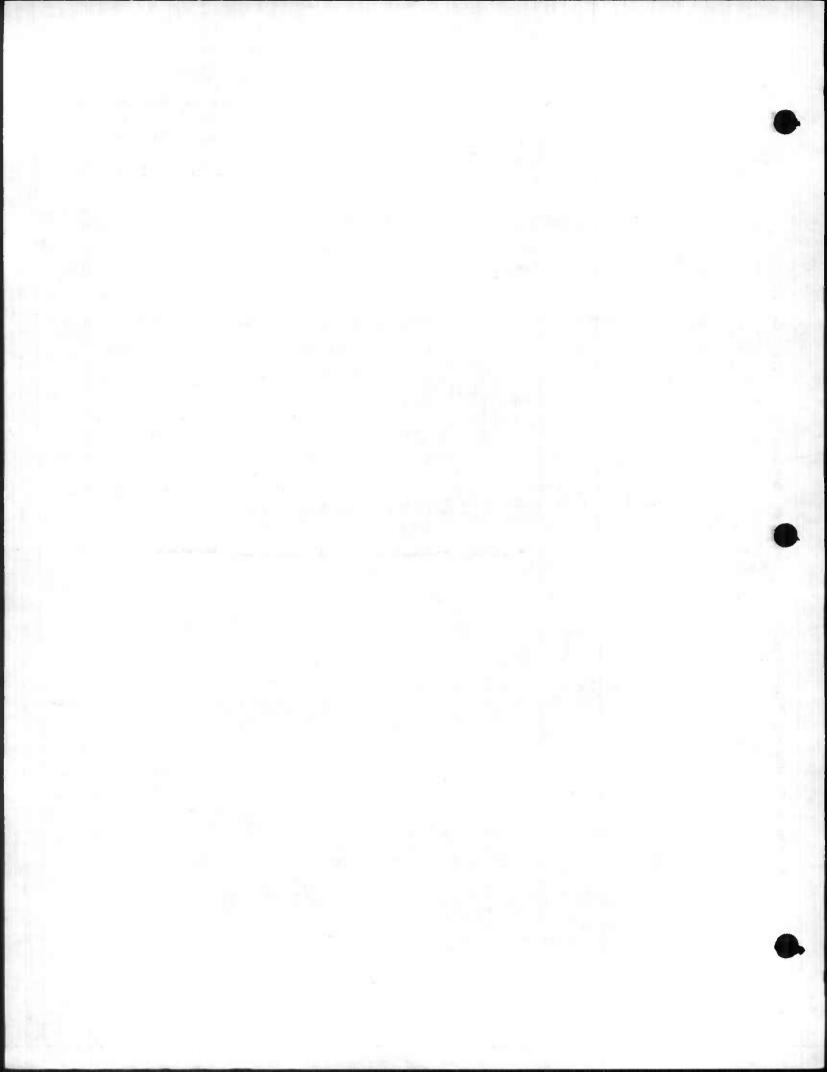
Registrar



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State of Maryland / Department of Health and Mental Hygiene

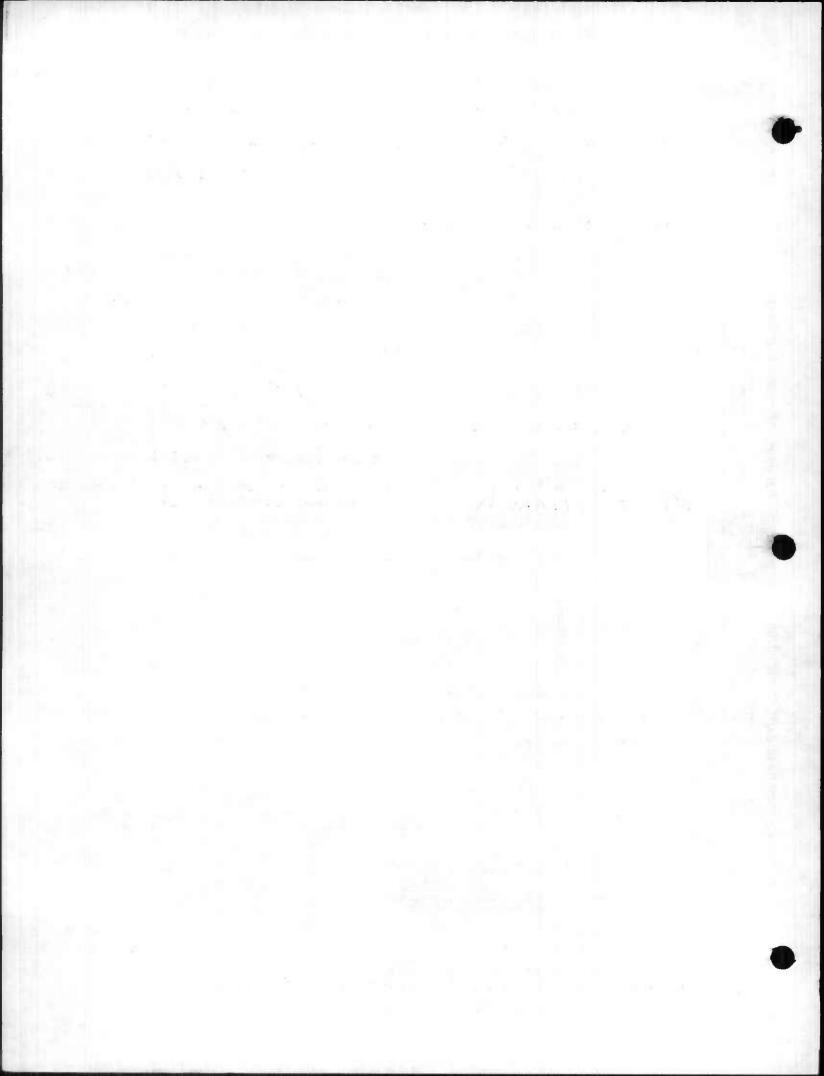
				Cer	tificate	of .	Death		Re	g. No.	3	1981		
Physician	Exercise the state of the state	Decedent's Nema (First, Middle, Last)							2. Date of Death Month Day Ye			3. Time of Deat		
Physician /Medical	Eugene Cliften			_			er 20,		0827					
Examiner	4a Facility Neme (If not institution, g	·				- 1	4b. City, Town,	or Location	of Death	4c. County	of Death			
	Washington Cour							agers		Washi	ngto	n		
Funeral Director	214-09-3970		ge (In yrs. last 93	birthday) Yrs.	If Under 1 Months	Days		Ain. (A	ate of Birth fonth, Day, C • 24	Year) , 1905	Count	rthplace <i>(State or Foreig</i> country) st Virginia		
E R	Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation						10	d. Inside City Lin		
Maryland of show find at tor	Maryland Washir	naton		Насе	erstow	m						NXYes 2□		
or 28e4 s be notified Director	10e. Street and Number	.80011		1145	10f. Zip (10	g. Citizen of W	/hat Coun	ny?		
A P		la Avenue			21	740)			USA				
urs after death with the Maryla st, or herns 23a or 28e4 shor Examiner must be notified at by Funeral Director	11. Marital Status 1 Never Merriad 2 Merried	12. Was Decedent Armed Forcas?	,		Vas Decede Yes, specif		dispanto Origini an, Mexican, P	? (Specify Yuerto Rican	es or No-	Blac	- America k, White, c	itc.		
			10	6a. Decede	ent's Usual	Occup	ation		1	6b. Kind of Bu	siness/Ind	ustry		
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yene r than the Me	12	O O	College (1-4or 5+)			eser	ntative			invest	ment	3		
E 185 6		st)	18. 8				18. Mother's	Neme (Firs	t, Middle, M	laiden Sumam	Θ)			
	John P. Ryan	John P. Ryan						Minn	ie A.	Hare				
g p E E	19e. Informent's Neme/Reletionship	(Type, Print)	1	19b. Meilin	g Address ((Street	and Number o	r Rurai Rou	te Number,	City or Town,	State, Zip	Code)		
and 2 saith a n 27 is ser trau	Don Hovermale - H	Per. Repre.	. 1	7738	Broad	lfor	ding R	d., H	agerst	town, M	id. 2	L740		
- T 5 5	20a. Method of Disposition		come	of Dispos	sition (Nemo	e of	cal	De	te 2	Oc. Location -	City or To	wn, Stete		
Pages set at lot ery or o	1 ☑ Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec				en Cen			11-23	_99 T	Hagerst	own . I	Maryland		
porter y injur	21. Signeture of Funeret Service Lice		- Rebe)				iar y rand		
Dep Dep Many Many Many Many Many Many Many Many	21. Signeture of Funeret Service Licensee 22. Neme end Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740										21740			
Physician	shock, or heart feilure. List only one cause on each line.										Approximete Intervel Between Onset and Death			
/Medical	Immediate Cause (Finel disease or condition Autorio 1 Lensie Cardioranales Dinas										m			
Examiner	resulting in death)	0	Due to (or es	VIV. 2007							1			
D # 5														
tificate be executed g physician and as the bunal-transit Aedical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of):													
ysicie be bu	Cause (Diseese or Injury thet initiated events	C	Due to (or es	e consequ	ience of):						-			
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death ce a attendir ad for use sician/I											1			
at the death certing d by the attending setached for use a Physician/M	Part II. Other significant conditions	art II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.								See State Brillia				
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seen s should								_ 2	24a. Wes ar perform		ava	re sutopsy findin- ilable prior to apletion of cause leath?		
scient: The lew s certificate has to director, page 2 and o Be Compli									1 □ Ye	s 210 No	10	Yes 2□ No		
entifica actor, p	25. Wes case referred to medical						26. Place of	Deeth /Che	and the same					
this certific ral director,	exeminer? 1 ☐ Yes 2 ☒ No	Hospitet:	ent 2 N FR/	Outpatient	3□ DOA	Oth	NOF:			nce 6 DOthe	er /Snecih	d		
erthis eral di	27. Menner of Death	28a. Dete of Inju	iry 281	b. Time of		c. Injur Wor				w injury occurr		,		
. 45 0	1 ☑ Neturel 5 ☐ Panding 2 ☐ Accident Investigeti	(Month, Da	ly rear)	Injury M			Yes 2 □ No							
# 0 P		d 289. Piece of in	Injury - At home, ferm, street, fectory, office etc. (Specify)				28f. L	28f. Location (Street and Number or Rural Rou City or Town, State)						
s after death. I Director: After de in by the fune	3 Suicide 6 Could not 4 Homicide determine	29a. Cartifier (Check only Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.												
hospital or Attending P Funeral Director: After telety filled in by the funeral director. After telety filled in by the funeral director.	4 ☐ Homicide determine 29a. Cartifier 1⊠ Certifying P	Physician: To the best iminer: On the basis of and manner st	examinetion	dge, deeth and/or inve	occurred el estigation, i	in my o	pinion, deeth o	occurred at	ue to the ca the time, da	use(s) and ma ite end plece, a	nner as st and due to	ated. the cause(s)		
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within 24 hours after death. To the Funeral Director: A completely filled in by the fi	29a. Cartifier (Check only one) 29b. Signatura and title of certifier 30. Nama and address of person who	aminer: On the basis of and manner sto	f examination eted.	and/or Inve	estigation, i 29c.	Licens	e number	occurred at	the time, da	te end plece, a	ind due to	Day, Year)		



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** November 16,1999 0235 Anna Elizabeth Reese /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Julia Manor Health Care Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2X F Yrs. September 24, 1925 Maryland 74 220 16 1809 Director Usuel Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Directo Maryland Washington Hagerstown 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be a 21740 USA 7 East Washington St. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detas: 1 Nevar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ➡ No Specify: Specify: White p 3 ₩ Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filled within 72 h. Doperment of health and Mental hygione. Important if them 27 is merked other than any injury or other traument. 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Sylvia L. Garrett 10 Arley Chris Barry 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercersburg, Pa. 17236 Son Milton W. Huyett 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 XBuriel 2 Cremetion 3 Removel from Stete Greenlawn Memorial Park Williamsport, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Gerald N. Minnich Signeture of Funerel Sarvice Licensea 305 N. Potomac St. 21740 Hagerstown, Maryland Za. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Intervel Between Onsat end Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) /Iviedical Anteris relente anna Examiner Due to (or as e consequence of): Examiner certificate be executed physician and s the burial-transit Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events rasulting in deeth) Lest Due to (or as e consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): USB as t P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the causa of death? á 1 Yes 2 No 3 Probably 4 2 Unknown malhering Division of Vital Records, by 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 24e. Wes en autopsy performed? Completed Hypothyrocurn 1 Yes 2 3 NO 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 10 10 After this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how Injury occurred 28b. Time of Certification: 5 Pending investigation or Attending 1 Maturel er deeth. 1□ Yes 2□No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 efter 4 Homicide Hospital 24 hours edicai 29e, Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner steted. within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifiar 29c. Licansa number D(80(9 -tona mo 16, 1777 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 21740 334 Mill Hagerstown, Md. Datta St. 31. Dete filed (Month, Day, Year), NOV 17 32. Registrar's Signature State Registrar



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State of Maryland / Department of Health and Mental Hygiene

			Otato of Mary		rtificate of		•	Reg. No.	9 3	37983		
Physic	rian	Decedent's Name (First, Middle, Le			Date of Daath Month Day Year			3. Tima of Death				
→ /Med		Anna Mae	Snyder			November 17, 1999 23:3						
Exam		4a. Facility Name (If not institution, giv	e street end number)			4b. City, Town, o						
ë		Washington Adven	tist Hospita	1		Takoma I	Park	Mont	gomen	rv		
1-unera		5. Social Security Number 6. S		rs. lest birthdey)	If Under 1 Year				0	place (State or Foreigntry)		
Directo	_	220-12-3414 Usual Residance of Decedent	□M 2XF 85	Yrs.	Months Days	Hours Mir	May 28	, 1914		yland		
and		10a. State 10b. County	10c.	City, Town or Lo	ocation				1	IOd. Inside City Limit		
Aary P	5	Warnell D.	0 1	0.11						1 X Yes 2 □ N		
the 1	Director	Maryland Prince	George's	Colle	e Park		-	40- 09241				
E 9 8	급				10f. Zip Code			10g. Citizen of \		itry?		
ath 23	<u>a</u>	8615 Rhode Islan			207			U.S.A				
er de	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕅 No	n U,S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No orto Rican, etc.)	- 14. Rac Blac	ca - Americ ck, White,			
permit. Peges 1 end 2 should be filed with 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Integrate 1 files with 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercites 1 and the notified an once.	by	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖎 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:			Specify	Whit	e		
2 hc	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occu	pation		16b. Kind of B	usiness/in	dustry		
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iw piene	E	7	Oollaga (1-401 54)	V	laitress			Resta	urant	nt		
office file	Be	17. Father's Name (First, Middle, Lest)				18. Mothar's Na	ame (First, Middla	Maidan Sumen	ne)			
d by	ToB	Edward Hanna				Viola	Catherin	e Mille	r			
shound M	-	19a. Informant's Name/Raiationship (Type, Print)	19b. Mailir	na Address (Street		Rural Route Numb			Code)		
trait		Catherine A. Bail	ev - Daughte									
Hea Hea		20a. Method of Disposition		b. Place of Dispo	sition (Name of		nue, Col	20c. Location				
or or		1 X Burlat 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer	netory or other pla	,			1			
oemit. Peges 1 er Department of Hea mportant: if item 2 sny injury or other ance.		4 □ Donation 5 □ Other (Spacify			coln Cem		11/20/99	Brentw	ood,	Maryland		
Depar Depar Impor any ir		XI. Signature of Fullyaray Service Licen	500		2. Name and Address		T					
Q □ # € 0		Tull will	2011) 4	ascn's r 739 Ralt	imore Av	lome, P.A venue, Hy	attevil	10 N	D 20781		
DETERMINE		23a. Port : Enter the charge or comp shock, or heart failure. List only	olications that caused The d	Do not ent	er the mode of dyi	ng, such as cerdi	ac or respiratory a	rrast,	Le , I	Approximata		
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/Medical	_	Immediate Cause (Final	St	= P S 1 S					14	weeks		
Examiner		disease or condition rasulting in death)	a. Dua t	o (or as a consec						weels		
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eath cer ettendin I for use	100											
es that the death cer gned by the ettendir be deteched for use	Physician/M	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying ceuse gi	van in Part I.	23b. Did	tobacco use co	ntribute to	e to the cause of death		
d by the						10	Yes 2 No	bably 4 Unknow				
es the	by						-		I			
been signature	ted						24a. Was	an autopsy	ava	ere autopsy findings allable prior to		
e law r hes be	pie				-				of	mpletion of cause death?		
Attending Physician: The law requires that the death certificete be executed ar death. ector: After this certificate has been signed by the ettending physician end by the funeral director, page 2 should be deteched for use as the buriel-transit	Completed						10	Yes 2 No	1Γ	☐Yes 2☐No		
ician: The certificate rector, pag	BeC	25. Was case rafarred to medical				26 Place of De	aath (Check only o					
Attending Physician: or death. ector: After this certific by the funeral director,	0	examinar? 1 ☐ Yas 2 No	Hospital: Inpatiant 2	ER/Outpatier	t 3 DOA Ot	har:	Home 5 ☐ Resid		or (Coasil			
Phy or this	⊢	27. Mannar of Death	28a. Data of Injury (Month, Dey Year		I 3L DOA	4 Li Nursing	_	now Injury occur		77		
ding th.	tloi	1 SNatural 5 ☐ Pending 2 ☐ Accident invastigation) Injury		rk? Yes 2□No						
or Attending Physician: The law requires the effect death. Director: After this certificate hes been signed in by the funeral director, page 2 should be d	Certification:	3 Suicide 6 Could not be		t home, farm, etc.			28f. Location /	Street and Numb	per or Rura	el Route Number,		
or lefter Dire	erti	4 ☐ Homicide determined	building, etc. (Spa	acify)	and the story, officer		City or To	vn, Stete)	5 / 10/0			
To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by		29a. Cartifiar Certifying Phy	valcian: To the bast of my	cnowledge, daath	occurred at the ti	me, data and plac	e and due to the	cause(s) and ma	anner as el	tated		
P Fulletely	edical	(Check only 2 Medical Examone)	iner: On the basis of axam and manner stated.	Ination and/or Inv	vestigation, In my	opinion, death occ	curred at tha tima,	date and place,	and due to	tha causa(s)		
o the	Me	29b. Signature and little of certifier)		29c. Licens	se number	T	29d. Date signe	d (Month	Dey, Yeer)		
F 3 F 8		ordisa	2 MD			53411				184,199		
(4)		30. Name and address of person who	completed cause of death (1	tem 23a) (Type,	Print)	# 103	Bruie	- MD	21	0716		
		,-					20 / 1/ 4			- ,		
	ate	31. Date filed (Month, Dev Yeer) NOV 191999	Registrar's Sig		1	. 165						
Regist	_	1000	1	B. ,	fort							
IMH 16 Rev 6/	73			-								

MON I 9 1938 Stemmer A. Marace

Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 2. Data of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last NOV (NIM) 5:00 pm 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Nama (If not institution, give street end number, Southern Maryland Hospital Center Clinton If Under 1 Yaar | If Under 24 Hrs. Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foraign Country) Hours XXM 2□ F Months Deys Min. Yrs. 84 10/6/1915 New York 052-07-6672 Usuel Residence of Deceden 10b. County 10c. City, Town or Location 10d. fnslda City Llmits 1 Yas 2 No Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 9211 Stuart Lane 23051 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? Bleck, Whita, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yas XXNo Specify: XXWidowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) Sales Liquor 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Syetta Unobtainable 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) David Harris Syetta/ Son 2408 Mark Twain Dr. Antioch, CA 94509 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

King David Mem. Grdns. 11/19/1999 Falls Church, VA 22. Nama and Address of Fecility National Funeral Home

20c. Location - City or Town, Stete

Approximete fntarval Between Onset end Death

24b. Were eutopsy findings availebla prior to complation of causa of deeth?

1 ☐ Yes 2 ☐ No

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avent, the Medical Examination not be not the page.

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

10a, Stata

Jake

20e. Method of Disposition

XX Burial 2 Cremation 3 Removal from Stata

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funerel Service Licensee

Directo MD

Funeral

by

Completed

Funeral

Director

Physician /Medical Examiner

director. funeral

Examiner Physician/Medicai þ Completed

physician and the burief-transit lew requires that the death certificate be executed for use as t been signed by the should be deteched s certificate has b Certification: To 3

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice To the

7482 Lee Hwy Falls Church, VA 22042 ucina 23a. Part1. Entar tha disaasa, or complications thet ceused tha deeth. Do not enter the mode of dying, such es cardiec or respiretory arrast, shock, or heert feilure. List only one ceuse on each line. Immediate Ceuse (Finel Hemoptysis diseese or condition resulting in deeth) Dua to (or as e consequence of) Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Cerebro vascular accident Due to (or es e consequence of Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy 1 ☐ Yes 2 NO 25. Was case referred to medicel examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 ER/Outpetlent 3□ DOA 1 Inpatient 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and dua to the cause(s) end menner steted. 29e. Certifier 29d. Deta signed (Month, Day, Year) 29b. Signature and title obcertibe 29c. License number animiau erson who completed cause of death (Item 23e) (Type, Print)

NET AVE SE #200 W.Q. 30. Neme end eddress of p jou thern

State Registrar 31. Data filed (Month, Day, Yeer)





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DHMH 16 Ray 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death November 14, 1999 **Physician** William . F. 10:45am Stewart, Sr. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9160 D'Arcy Rd. Upper Marlboro Prince George's Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Sept. 24, 1920 Upper Marlboro, Md If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1₩ M 2□ F 214-28-9005 79 Yrs. Director Usual Residence of Decedent with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r 28a-f show undiffied at 1K Yes 2 No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or itsms 23s or 9160 D'Arcy Rd. 20774 United States Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 20 Merried Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 2♥ No Specify: þ 3 Widowed 4 Divorced Year or Dales: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyplene. Elementery/Secondery (0-12) College (1-4or 5+) 11 Carpenter Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Meetal Hy Important: if fleen 27 is marked oth any letury or other treametic event BOS. 89 Osborne Stewart Kathryn Greenleaf 10 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Louise Stewart/Wife 9160 D'Arcy Rd. Upper Marlboro, Md. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 11/20/99 Clinton, Md. 4 ☐ Donelion 5 ☐ Other (Specify) Resurrection Cemetery 21. Signature of Funeral Service Line 22. Name end Address of Facility

Physician /Medical Examiner

physician and the burial-transit

080

signed by it

page 2

certificate

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalethy filled in by the funeral director; p

To the Hosp within 24 hor To the Fune completely fi

Certification: To

Medical

the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Physician/Medicai Paraplegic - Prostate cancer compressing spinal cord. þ Be Completed

Immediete Cause (Final

disease or condition resulting in deeth)

Tar

Adenocarcinoma of Prostate

Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line.

20747 Approximate Interval Between Onset and Deeth

Due to (or as a consequence of):

Cardiovascular Collapse

Due to (or es e consequence of):

Due to (or es a consequenca of):

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an eutopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of death?

2 Years

1 ☐ Yes ZENo

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospitel: 1 Yes 2₺ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Menner of Death 1 Netural 5 Pending investigation 2 Accident

28a. Dete of fnjury (Month, Dey Year) 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

281, Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title ot certifier

29c. License number MD25272

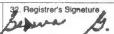
29d. Date signed (Month, Day, Year) November 16, 1999

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Robert F. Blythe, M.D.

1104 Spring St. Silver Spring, Md. 20910

State Registrar 31. Dete tiled (Month, Dey, Year) NOV 17 1999





Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Elvida Simms Marie November 13,1999 3:30 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner 14113 Spring Branch Drive Prince Geroge's If Under 1 Yeer 8. Deta of Birth (Month, Dey, Yeer) Jan 20, 19 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min. 1 M 2 Yrs. 218-20-2323 A 84 Pennsylvania Director Usuel Residence of Decedent tha Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☐ No Directo MD P.G. Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Pegas 1 and 2 should be filed within 72 hours after death with nant of Hatilh and Mental hygiene.
If item 27 is marked other than "natural", or items 23a or many or other traumatic event, the Medical Exertine manifer any 20772 14113 Spring Branch Drive United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, 2000 to tyes, Give Yaar or Detes: 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2XXNo Specify: Specify: by **3**CXWidowed 4 □ Divorced Completed 16e. Decedant's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elamantery/Secondery (0-12) College (1-4or 5+) Title Record Seacher Upper Marlboro Court-18. Mother's Nama (First, Middla, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) Livia Biancaniello Antonio Pometto 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Name/Relationship (Type, Print) 14608 Main Street Apt 3, Upper Marlboro, MD 20772 Elvida McKnight (DAUGHTER) Baltimore, 20b. Ptace of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial ②Coremetion 3 ☐ Removel from State permit. Pega Department of Important: If any injury or once. Lee Crematory Nov 15,1999 Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Licensee 22. Name end Address of FecilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23e. Pert1. Entar the disease, or complications that caused tha deeth. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediete Cause (Finel diseese or condition resulting In death) Yeous Examiner Examiner Chylo thovax physician and s the burial-trensit requires that the death cartificate be executed Sequentielly list conditions, if eny, taading to immediate ceusa. Entar Underlying Cause (Diseese or injury that initleted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760 ot uemia Physician/Medical Due to (or es e consequence of) for usa es 1999 Clys vy Hunce Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to Completed 24e. Wes en eutopsy completion of cause of daeth? paga 2 s 1 Yes 2 No 1 ☐ Yes 2 No certificata Hospital or Attending Physician: 24 hours after death. Funeral Director: Aftar this certific funaral director, 25. Wes cese raferred to medicel examiner? 26. Plece of Deeth (Check only one) Hospital: Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 1 Neturat 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Phyelclan: To tha best of my knowledge, deeth occurred et the time, date end place, and dua to the ceuse(s) and mannar as stated.

2 ■ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner steted. 29e. Certifier To the Hosp within 24 hou To the Fune complately fi edical 29d. Date signed (Month, Dey, Yeer) 29b. Signatura and title of certifier 29c. License number leunpala 1999 6. 13 30. Neme end eddrass of person who completed ceuse of deeth (Item 23a) (Type, Print) Alain G. Champaloux , M.D. 14314 Old Marlboro Pike, Upper Marlboro , MD 20772 32. Registrer's Signeture 31. Data filed (Month, Dey, Yeer) State NOV 1 6 1999 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1999 7:39 P.M. Nov. 14, Helen E. Swann /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Southern Maryland Hospital Center Clinton Prince Georges If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 M 2EKF Feb.11, 579-07-1817 1915 Washington, D.C 84 Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified as 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Directo Maryland Anne Arundel Churchton 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20733 USA 1218 Fairfax Avenue Funeral 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2\\ No If Yes, Give Yeer or Deles: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ₩idowed 4 □ Divorced Completed 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Bindery Worker Graphic Arts 18. Mother's Neme (First, Middle, Malden Surname) 17. Fether's Neme (First, Middle, Last) Be J. Raymond O'Dwyer Emma Dechard 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 1218 Fairfax Ave., Churchton, MD 20733 Richard C. Swann, Jr./Son 20b. Plece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 11/18/1999 Suitland, MD 21. Signature of Funeral Service Lice 22. Name and Address of Fecility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel em disease or condition rasulting in daeth) Examiner Examiner The law requires that the death cartificate be executed physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting In deeth) Lest Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): 55 987 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yee Completed by 24b. Were eutopsy findings available prior to completion of cause ot daath? 24e. Wes en eutopsy cartificate hes t director, pega 2 s 1 Yas 27 NO 1 Yas 2 No Hospital or Attending Physician: diractor, Be 25. Wes case rafarred to medical 26. Piece of Death (Check only one) exeminer? Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residance 6 Other (Specify) 2 No 10 1 Yeş 20 ER/Outpetient 3 DOA this funaral 27. Manper of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Aftar 1 Neturel Injury 5 Pending death. 1 Tyes 2 No investigation 2 Accidant after deatl 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Phyeician: To tha best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) and mennar as stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) end menner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartifier anse number 30. Name end eddress of person who complated causa of death (Itam 23a) (Type, Print) 7700 Old Branch Ave., #C101, Clinton, MD 20735 Laxmi N. Berwa, M.D. 31. Dete filed (Month, Day, Year)

State Registrar

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32. Registrer's Signature

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) November 4, 1999 **Physician** Verner A. St. Cyr 9:00 P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Gladys Spellman Nursing Center Prince Georges Months Days Hours Min. Dec (Month, Day, 1) 644 (4) 9. Birthplaca (State or Foreign Trinidad 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□F 217-66-8653 54 Yrs. **Director** Usual Rasidence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryle Department of Health end Mental Hyglene. Important: If itam 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be northed an once. 1 ☐ Yes 2 ☑ No Prince Georges Cottage City 10f. Zip Code 10g. Citizen of What Country? 4005 Parkwood Street 20722 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 Navar Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade complated) College (1-4or 5+) Elementary/Secondery (0-12) Construction worker Construction 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar'a Name (First, Middle, Last) Eli St. Cyr Jemima Davidson 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) Joseph St. Cyr/ Brother 4700 Edmondson Ave. Baltimore, MD 21229 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ Ramoval from State Ft. Lincoln Cemetery Nov. 12, 1999 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig 22. Nama and Addrass of Facility Ft. Lincoln Funeral Home ellou 23a. Part1. Enter the diseasa, or complic shock, or heart failure. List only on 3401 Bladensburg Rd. Brentwood, MD tions that ceused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, cause on each line. 20722 Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in death) Aspiration Examiner Examiner Respiratory physicien end the buriel-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initieled events resulting In death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Arrest Physician/Medical Due to (or as a consequence of): encephalo palling esn Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown Persiptent Vegetative State 24b. Were autopsy findings availeble prior to complation of causa of death? 24a. Was an autopsy performed? Diapeter mellelay, Seizure clesor cle Y 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cest referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Mennes of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Netural after deeth. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 I Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) To the To the To the I 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) Navay Kalpana Comothy D0052848 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) NANCY K. TIMOTHY
5807 ANNAPOUS RD, HYATTSVILLE MD - 2072 RD , HYATTSVILLE mD -20784 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 6 1999 Registrar Sparker

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) November 12, 4999 **Physician** 1:10pm Wayne A. Scott /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Yaar If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 187 M 2□ F Yrs. July 24,1934 500-34-4070 Director 65 Missouri Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at Md Montgomery Silver Spring X☐ Yes 2☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 10805 20901 USA Childs Street Nerns 23a Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Stelus Vermit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

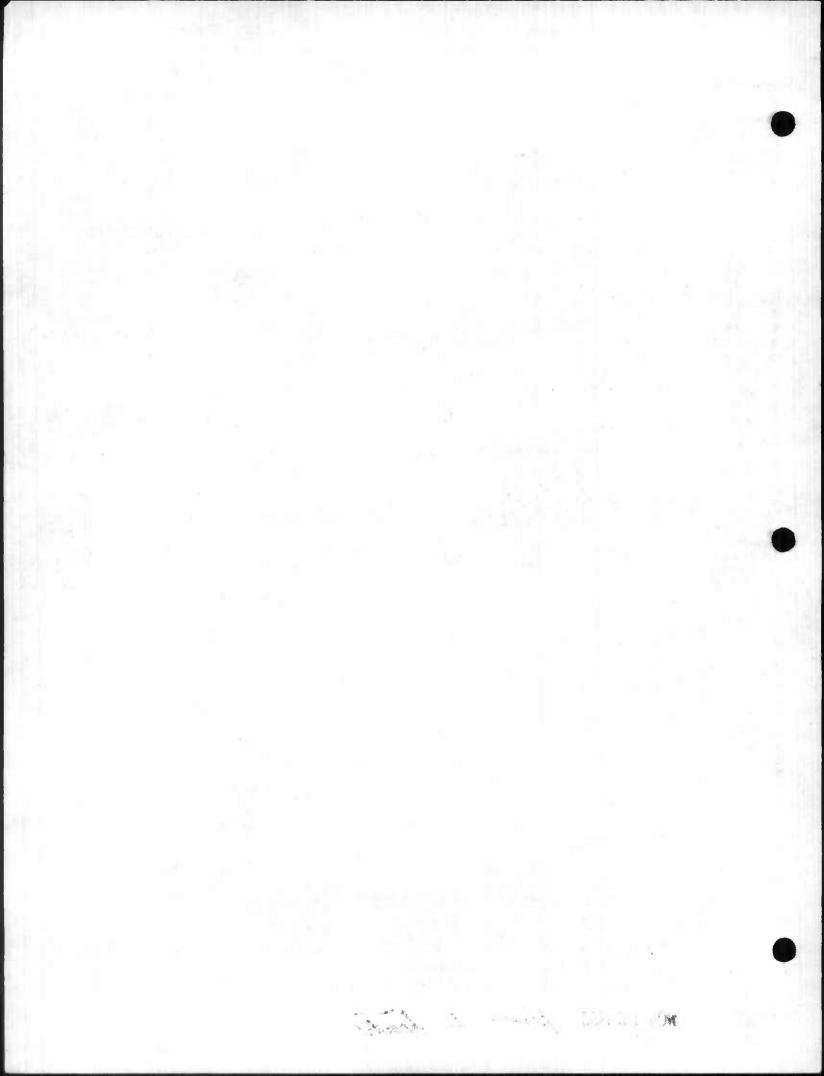
Important: if item 27 Ia marked other than "natural", or item any injury or other traumatic avent, the Hedical Esam and DECE. Bleck, White, etc. 1 Yas 2 XNo If Yes, Give Yaer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Maryland Diagnostic Elementery/Secondary (0-12) College (1-4or 5+) Delivery Imaging 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Falher's Nama (First, Middla, Last) Be Blanche E. Hoskins Jasper A. Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 19a. Informent's Neme/Reletionship (Type, Print) 10031 Brunett Avenue, Silver Spring, Md Helena Orellana/ Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stele 11/13/99 Metropolitan Alexandria, Va. 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signature of Funeral Services License 22. Name end Address of Fecility wille Philip D.1 11818 New D.Rinaldi Funeral New Hampshire Ave. Service Silver Spring, Md 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final Cancer 996 disaese or condition resulting in death) Examiner Examiner burial-transit Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Diseese or Injury Ihet initiated events resulting in death) Lest and Due to (or es e consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 Ves 2 No 3 Probably 4 Unknown Records, þ been sig 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 2 DNo certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medicai Certification: To 2 ER/Outpatient 3 DOA 28e. Dele of Injury (Month, Dey Year) 27. Mennes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 PNaturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - Al home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29b. Signatura and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) - 20062 Nov 12, 1999 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, 8201 16th St Kannarkat MD Md 20910 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture

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State Registrar

NOV 1 5 1999



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Mercedes Lina Soto November 13,1999 11:20am /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randolph Hills Nursing Home Wheaton Montgomery If Under 1 Yeer If Under 24 Hrs 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 TF 577-06-3202 68 Sept.27,1931 Director Nicaragua Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Md Silver Spring 1 Yes 2 No Director 28a-fi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be n 3515 Pear Tree Court Apt.#34 20906 Perm.Resident USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus filed within 72 hours after 1 ☑ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 xCxyes 2□No Specify: Nicaragua Specify: Hispanic à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Etementery/Secondary (0-12) College (1-4or 5+) Housekepping Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H ant: if Nem 27 is marked oth lury or other traumatic even Be Concepcion Valle Gregoria Soto 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19e. Informent's Neme/Reletionship (Type, Print) Maria Luisa Lopez/Sister 3515 Pear Tree Ct.Apt#34 Silver Spring,Md 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State ty□ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Maryland National 11/16/99 Laurel Md. 5 Other (Specify) 21. Signeture of Funeral Service License 22. Name end Address of Fecility Philip D. Rinaldi Funeral Service 11818 New Hampshire Ave.Silver Spring,Md 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** LYMPHOMA Immediate Ceuse (Finet disease or condition resulting in deeth) /Medical Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last pug Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): for use Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 20 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? paga 2 certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medicat axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? After ! 1 Naturat 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attand within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. 29e. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of parson who completed cause of death (ttem 23a) (Type, Print) 20895 ARRAGUT AVE KENGUETON SHARDEL MD 0 MARTIN

DHMH 16 Rav 6/95

State

Registrar

31. Dete fited (Month, Dey, Year)

NOV 1 5 1999

Megistrar's Signature

40V 1 5 1889 James B. April

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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edical miner	4a	4a Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death 4c. County of Death					
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Director	Ma	Maryland Montgomery Silver Spring									1 ☐ Yes 2 ☑ N	
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<u>6</u>		9313 Avenel Rd				20903	3		United	States	3	
e e	11	. Marital Status	12. Was Deceden Armed Forces	t Ever in U,	S. 13. Was De	ecedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, atc.)	- 14. Race Blec	- American k, White, etc		
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		Betty Gamerman/	Sister		8107 Eas	stern	Ave. #D3	01 Silve	er Sprin	g, MD.	20910	
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State Registrar

NOV 2 4 1999

Stephen 31. Dete filed (Month, Day, Year)

5.



111 Penn Street, Baltimore, Maryland 21201

13 June B. francis

MOV 2 4 1999

99-6862-033

SARAH SMITH-HI	ETC	AMEND ITEMS:	State of Mar #23 PART	yland / De	partment o	f Hea	alth and M	ental Hygi	ene o		7993
Physic /Medi		1. Decedent's Name (First, Middle, Las Sarah Smith-			2. Data of Death Month NOVEMBE	Dey	Year	ima of Death):22P.M.			
Exami	_	4a Facility Name (If not institution, give			City, Town, or Lo	cation of Death					
Funeral Director		LORIEN NURSING HOLDS: Social Security Number 6. Str. 578-56-2819		In yrs. last birtho	Months Da	ear If	OLUMBIA Under 24 Hrs. Hours Min.	8. Dete of Birth Month, Day, Jan. 24	HOWAR	9 Birtholace /	Stete or Foreign
Varyland f ahow	JO.	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	Oc. City, Town o	r Location eenbelt						side City Limits
after death with the Manylar or Nems 23s or 28s-f show	al Director	10e. Street and Number 8541-A Greenbelt		10f. Zip Co	de 2077	0	10	g. Citizen of W Unite	hat Country?	es	
5-0020 72 hours after death with the Manyland natural; or Hems 23s or 28s-f ahow seal Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	er in U,S.	3. Wes Decedent If Yas, specify (Cuban, N	nic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race Black Specify:	American Inc.	an
Z 1 Z 1 3-00 Z 0 d within 72 hours af jiens. r then "natural", or the leafest learn	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. De	cedent's Usual Ocive kind of work do e. DO NOT use re	ccupation	n ng most of workir	ng 1	6b. Kind of Bus	siness/Industry	
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tai Hy	To Be C	17. Father's Name (First, Middle, Last) John Shields				18.		(First, Middle, M cca John		9)	
Maryle 42 should h end Men 7 ie marke traumatic		19a. Informant's Neme/Relationship (7			eiling Address (St					State, Zip Code)
CTN	ŀ	Elizabeth Kella 20a. Method of Disposition		20h Place of D	8 Azalea sposition (Name of crematory or other	d .	rt, Lar		20774 Oc. Location - 0	City or Town, S	tata
Pages nant of mr: If its		1 Burial 2 Cremetion 3 4 Donation 5 Other (Specify			v Memori		ark 11	/22/99	Landov	ver. MD	
Baltimore, yemit. Pages 1 ar gepartment of He moortant: If the moortant: If then and		21. Signature of Funeral Service Licen	see		22. Nama and A				Funeral Home		
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/Medical Examiner	her	Immediate Cause (Finel disease or condition resulting in death)	HYPERTE WITH BR		CARDIOV FARCTIO				BÝ PNE	SE	A Part and Death
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		30. Name and address of person who of the company o	completed cause of deat CORC 32. Registrar's	wills		nn S	treet, E	Baltimor	e, Mary	land 21	1201
Sta Regist		NOV 1 9 1999	Selection of the select	A.	hand						

DHMH 16 Rev 6/95

30 V 2 8 1999 Summer A. Annelli

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent'a Name (First, Middla, Last) **Physician** Edna Cecelia Smith October 8:55 a.m. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner St. Mary's Ridge 49270 Curley's Road | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yagr) | January 11,1925 5. Social Security Number Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 219-12-3813 74 Yrs. Maryland Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland St. Mary's Ridge 1 ☐ Yes 2 ■ No Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be r 49270 Curley's Road 20680 United States Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Sfetus hours after 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify: Black ρ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker n/a 12 17. Felher's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) should be Mental Benedict O. Hopewell Lila V. Smith 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. informant's Name/Relationship (Type, Print) Ē Pages 1 and 2 49270 Curley's Road, Ridge, Maryland 20680 Raymond Smith, Husband of Health Items 27 20b. Place of Disposition (Name of cematary, cramatory or other place)

St. Peter Claver Cemetery 11-6-99

St. Inigoes, Maryland 20a. Method of Disposition Department of important: If its 1 ■ Burial 2 □ Cremellon 3 □ Removal from State 8 4 □ Donation 5 □ Other (Specify) 21 Separate of uneral separate language of the 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Aute Respirater Failur /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner arialom - of portria physician end the burial-transit the death certificate be executed Due to (or es a consequenca of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760 Physician/Medicai that initiated events resulting in death) Last Due to (or as e consequence of) 88 use ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, by The law requires 24b. Were autopsy findings eveileble prior to been si 24a. Was an autopsy performed? Completed completion of cause of death? s certificate hes t 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
24 hours efter death.
 Funeral Director: After this certificately filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home A Residence 6 Other (Specify) 1 ☐ Yes 2 ■ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yaar) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) Kometh D36206 11/2/51 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Kiran D. Mehta, M.D., 24035 Three Notch Rd., Hollywood, Maryland 20636

32. Registrer's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Yaar)

NOV 03 1999

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State of Maryland / Department of Health and Mental Hygiene O

Certificate of Death

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3. Time of Death

2:00 p.m.

10d. fnside City Limits

Approximate Intervel Between Onset and Death

1 ☐ Yes 2 ■ No

1. Decedent's Name (First, Middle, Last) 2. Dete of Death November 5, 1999 **Physician** Gertrude Delores Somerville /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner 45941 Millstone Landing Road Lexington Park St. Mary's 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) March 18,1936 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 ■ F 579-70-7959 63 Yrs. Maryland **Director** Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location r 28a-f ahow a notified at Maryland St. Mary's Lexington Park Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours efter death with nent of Heatth and Mental Hygiene.
nt: if Itam 27 is marked other than "natural", or items 23s or irry or other traumetic event, it a Madical Examines mast be no 45941 Millstone Landing Road 20653 United States Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ■ Married 1 ☐ Yes 2 ■ No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker n/a 12 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Alexander Spears Idola Marie Fenwick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653 19a. Informant's Name/Relationship (Type, Print) Thomas D. Somerville, Husband 45941 Millstone Landing Road, Lexington Park, MD altimore, 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Inmediate Heart of Mary 1 ■ Burial 2 □ Cremation 3 □ Removal from State 11-11-99 Lexington Park, Maryland Department of important: If any injury or 4 Donetion 5 Other (Specify) 22. Name and Address of Facility
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28. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **≥**Physician CARDIO RESPIRATORY ARREST /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner**

Examiner

Physician/Medicai

by

Completed

Be

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Certification:

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physician and the burial-transit that the death certificate be signed t page 2

P.O. Box 68760,

Records,

Division of Vital

certificate this funeral After ni or Attending s efter death. i Director: Aft yd ui

Due to (or es e consequence of): METASTATIC COLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last RENAL PAILURE Due to (or as a consequence of): ON INSULIA DIABETES MELLITUS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

HYPERTENSION SIP RIGHT KIDNEY TRANSPLANT 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA

24b. Were autopsy findings available prior to 24a. Was en autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Deeth 5 Pending Investigation 1 Natural

2 Accident 3 Suicide

28a. Date of Injury (Month, Dey Year) 6 Could not be

28b. Time of

28c. Injury et Work? 1 Yes 2 No

Other: 4 ☐ Nursing Home 5 ■ Residence 8 ☐ Other (Specify) 28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Yeer)

m.D.

00051738

11.09.1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Kae T. Aung, M.D., 24435 Mervell Dean Road, Hollywood, Maryland 20636

State Registra

31. Date filed (Month, Day, Year) NOV 0 9 1999





Hospital o 24 hours of Funeral Di

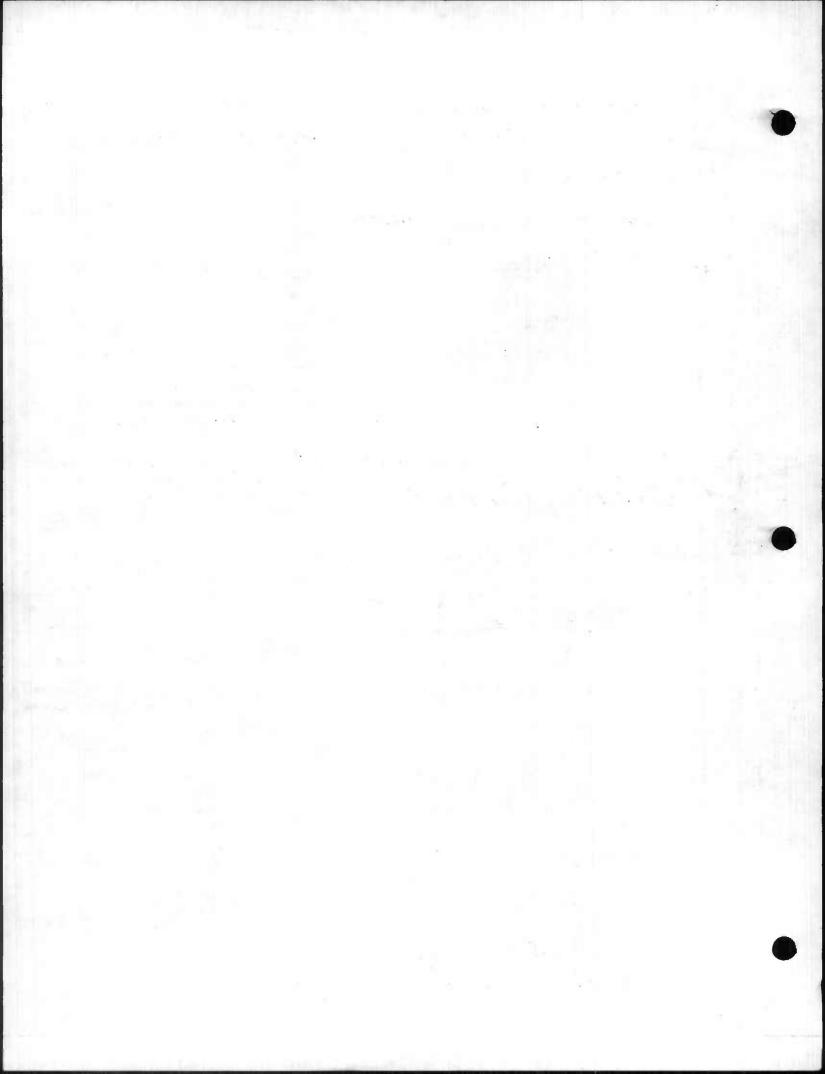
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** NOVEMBER 22, 1999 5:05AM Erna Lucie SPAULDING /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON 5. Social Sacurity Number 6 Sev 7. Aga (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🖾 F Hours Director 195-28-3537 Dec. 18 1914 84 Germany Usual Rasidanca of Decedant 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 27 No Directo 288-71 Maryland Washington Hagerstown 94 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 munt be Berns 23a 21740 U.S.A. 17635 Burnside Avenue Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after I ☐ Yes 2 No 1 Nevar Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White "natural". Year or Dates Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Her own home permit. Pages 1 and 2 should be filled Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, II 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Surname) Be Emilie Poschitzke Heinrich Schuetz 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 712 Winter Pine Drive Mars, Charles H. Spaulding - Son Pa. 16046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20c. Location - City or Town, State Data 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 11/24/99 Hagerstown, Maryland Rest Haven Cemetery 22. Nama and Address of Facility Minnich Funeral Home 21. Signatura di Sarvice Licensas 415 E. Wilson Blvd. Hagerstown, Maryland 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in death) melinary Examiner Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) physician s the burial Box 68760. Physician/Medical Dua to (or as a consequence of) 88 for use signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. Erna Lucy SPAULDING Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No Attending Physician: funeral director, 25. Was casa rafarrad to medical axaminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Natural 5 Panding death. 1 ☐ Yes 2 ☐ No investigation n 24 hours after death le Funeral Director: A pletely filled in by the f 2 Accidant 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Ptace ol Injury - At homa, larm, street, lactory, office building, atc. (Specify) 6 4 Homicide 6 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. vithin 2 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 26a) (Type, Print) DR. EDSON MOODY MD. 1190 MT. AETNA RD. HAGERSTOWN, 21740 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State NOV 3 0 1999 Registrar Das No



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State of Maryland / Department of Health and Mental Hygiene 99 3799

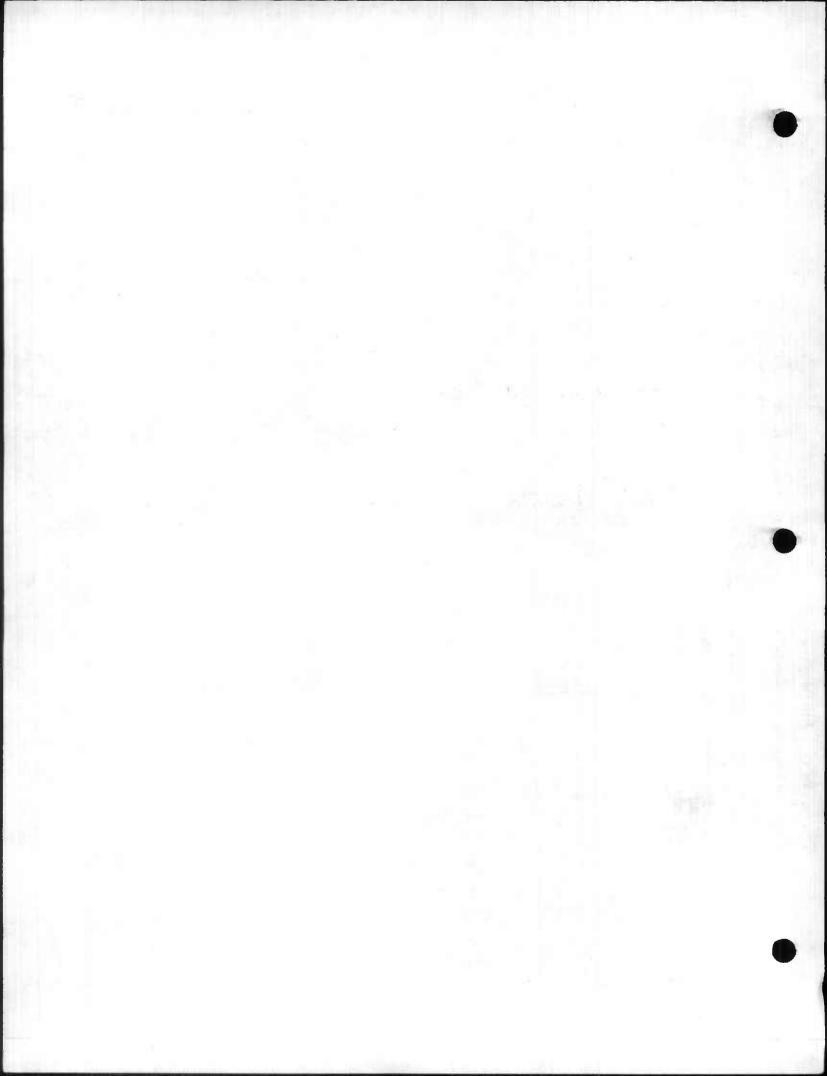
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aminer	4a Facility Nama (If not institution, giva street and nur	iber)		4b. City, Town,	or Location of Death	4c. County of Dea	th				
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al		7. Age (In yrs. last		ler 1 Year If Under 24 H	rs. 8 Date of Birth	9 Rid	thplece (State or Foreignanty)				
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990	Joseph Bernard McC	auley		Bess	io Catho	erine Wo	olford				
0	19a. Informant's Name/Relationship (Type, Print)		IOh Mailine Addes	es (Street and Number or							
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	20a. Method of Disposition 1 Burlal 2 □ Cramation 3 □ Removal from 9	ceme	a of Disposition (A etery, crematory o	r other place)	11724/99	20c. Location - City or	rown, State				
	4 ☐ Donation 5 ☐ Other (Specify)	Ced	ar Lawr	Memorial	Park 1	Hagerstow	vn, Md.				
	21. Signature of Funaral Service Licensee .)		and Address of Facility							
	S. ODY Muunh	,		d N. Minn:		N. Poton					
_	Jules 1 11 mman		Funer	al Home	Hage	erstown,					
	23a. Part1. Enter the disaasa, or complications that conshock, or heart failure. List only one cause on each	usad the death. Li ich line.	o not enter the m	ode of dying, such as card	liac or respiratory arri	est,	Approximate Interval Between				
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BE	2 Accident invastigation		М	1 ☐ Yes 2 ☐ No							
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildin	of Injury - At home, g, etc. (Specify)	, farm, street, facto	ory, office	28f. Location (St	28f. Location (Street and Number or Rural Route Number,					
5	Dullan	g, etc. (Specify)			Ony or row	or Town, State)					
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Me	29b. Signature and title of certifier	72	2	9c. License number	2	9d. Date signed (Moni	th. Dav. Year)				
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	30. Name and address of person who completed cause	of death (Item 23	a) (Type, Print)			,					
	Dr. MOGLY 1190	nt. Apt	na Rd	HAG WA	1						
e	31. Data filed (Month, Day, Year) 32. 9	gistrar's Signature		,							
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Shupp, Margaret

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State of Maryland / Department of Health and Mental Hygiene 99 37998

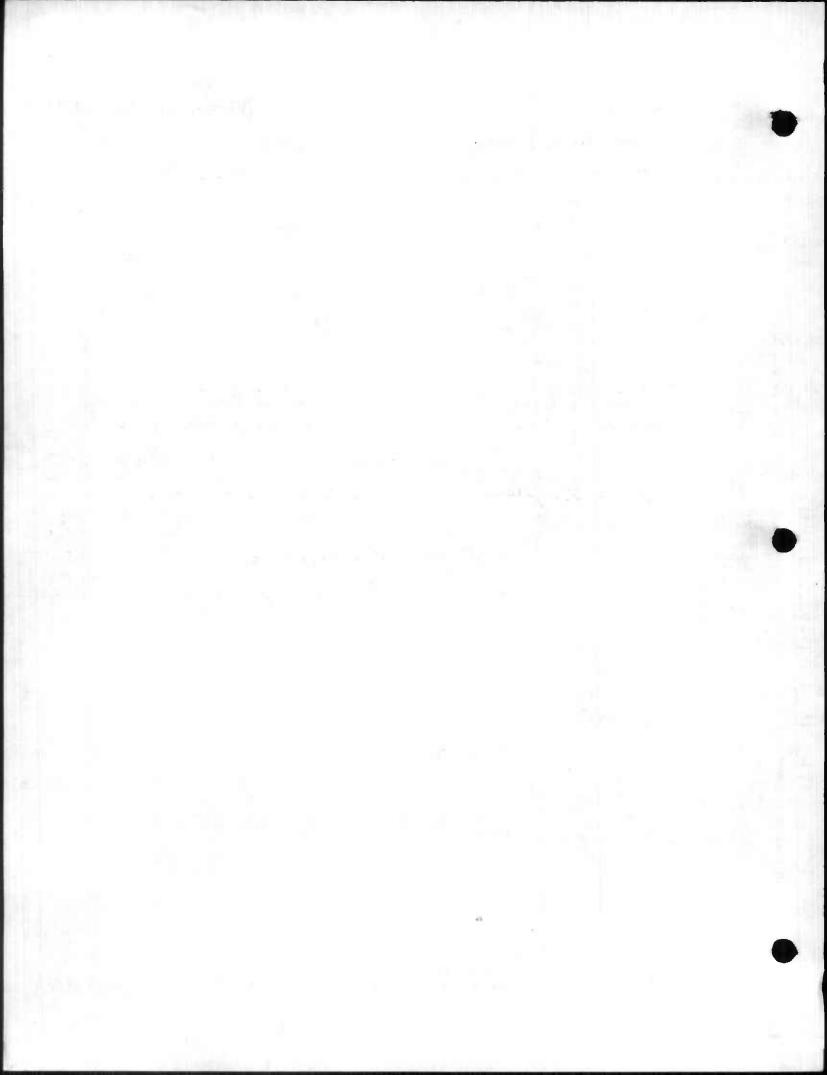
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	20	a. Method of Dis 1 2 Burial 2	*	3 □B	Removel f	rom State	CE	lace of Dispo	metory or	other plea			Dete	20c. Locatio			
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				Certificate of	f Death		Reg. No.			
0.	1. Decedent's Name (First, Middle	, Last)				2. Date of De	Bath Day	Year	3. Time of Death	
Physician Medical/	Martha Ruth Sc	Martha Ruth Schaff						1999	1840	
Examiner	An English Nome /M ant institution)		4b. City, Town,	NOV Plus or Location of Deat		y of Death		
LAGITITIO	Washington Cou	nty Hospita	1		Hagers	Lown	Washi	nator		
oral	5. Social Security Number		ge (In yrs. last birth	iday) If Under 1 Yea	ar If Under 24 H				place (State or Foreign ntry)	
neral ector	217-18-8588	1□M 2∏F		rs. Months Day	rs Hours M		ta of Birth onth, Day, Year) 9. Birthplace (Sta Country) 11 1912 Maryland			
	Usual Residence of Decedent		07			Aug. 1	1 1912	Mal	Land	
	10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits	
0									1 Yes 2 □ No	
Director	Maryland Washi	ngton	1	lagerstown 10f. Zip Code			10g. Citizen of	What Cou	ntry?	
Funeral	1744 Pennsylvan				21740			S.A.		
une	11. Marital Status	12. Was Decedent Armed Forces	?	 Was Decedent of If Yes, specify Cu 	f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	0- 14. Ra Bla	ice - Americack, White,	can Indian, , etc.	
by Fi	1 Never Married 2 Merri	ed 1 Tes 2 X	No	1□ Yes 2⊠N			Speci	ilv-		
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no:	12	0		ervisor			Chemic	al Mi	fg.	
Be	17. Father's Name (First, Middle, I	Last)	_		18. Mother's N	iame (First, Middle	, Maiden Surna	me)		
ToB	James W. Kauff	man			Emma 1	R. Clugst	on			
-	19a. Informant's Name/Relationsh		196.	Mailing Address (Stre				n. State. Zii	p Code)	
	Janet Porterfi	era - Siste		7925 SandWo	eage Dri	Date	20c. Location			
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	I some To	spran		415 E. W:	ilson Bly	vd. Hage	erstown,	Mary	yland 21740	
	23a. Pert1. Enter the disease, or	complications that cause	nd the death. Do no	ot enter the mode of d	ving, such as card	liac or respiratory a	arrest.	3	Approximata	
ın	shock, or heart feilure. List of	only one cause on each	line.		,	,			Intarval Between Onset end Deeth	
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i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
edicai	that initiated events resulting in death) Last									
n/Medical Examir		L.						1		
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							Ce	rtiticat	e or	Death	7		Reg. No	o		0000
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70	Ming Phys		27. Manner of Death		28a. Date	of Injury	28b. Tima o		8c. Inju Wo			28d. Dascribe				,
Division	ith. : After e funer	15 E	1 Natural 2 Accident	5 Panding Invastig		nth, Day Yes	(r) Injury	М		onk7]Yas 2. [No					
1 si	After des	fle	3 Sulcida	6 Could n	ot be 28a. Plac	e of Injury -	At homa, farm, st	reet, factor	, office	8		28f. Location (Street a	nd Numb	er or Rura	Routa Number,
그 등	Or Dint	Certification:	4 Homicide	Julianni		ling, etc. (Sp						City or To	wn, Stet	Θ)		
	spite sours neral		29e. Cartifier	1 Certifying	Phyaician: To the	a bast of my	knowiadga, daat	h occurred	at tha ti	ima data ar	nd place	and due to the	causa/s	and me	nner es et	nted
	Fur etaly	edical	(Check only one)	2 Medical E	xaminer: On the b	asis of axar	nination and/or Ir	vastigation	In my	opinion, das	ath occur	red at tha tima,	data an	d piece,	and dua to	tha cause(a)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	M	29b. Signature a/a	The Soldier		Julian Siatod.	1	290	. Licens	se number			29d. Da	ata signafo	(Month A	ay, Yearl
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-			30. Name and addre	ess of person w	no commated cau	sa of daath	(Item 23a) (Type,	Print)	-	1/2-	26	· //	1 -5"	the	co	your /1
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